DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Request for Applications (RFA) No. SM-03-009

Cooperative Agreements for the Comprehensive Community Mental Health Services Program for Children and Their Families

Short Title: Child Mental Health Initiative

Part I - Programmatic Guidance
First Application Due Date: August 5, 2003
Second Application Due Date: October 15, 2003

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Authority: Part E of Title V, Section 561 et. seq., of the Public Health Service Act, as amended and subject to the availability of funds.

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[Note to Applicants: To prepare a complete application, "Part II - General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements" must be used in conjunction with this document, "Part I - Programmatic Guidance."]

Agency

U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration

Purpose of this Announcement

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2003 and FY 2004 cooperative agreements to develop systems of care that deliver effective, comprehensive community mental health services for a target population of children and adolescents with a serious emotional disturbance and their families.

Funds will be awarded to develop community service systems for the target population and also to fund a broad array of services delivered through those service systems. In addition, awardees will participate in a national multisite evaluation, conducted through a separate contract, and will be encouraged to develop the capacity for continuous evaluation of their systems of care.

It is expected that approximately $5 million will be available for about five awards in FY 2003 and $5 million for about five awards in FY 2004. The maximum amount available in total direct and indirect costs for each year of the award will be as follows:

- Year 1: $1 million
- Year 2: $1.5 million
- Year 3: $2.5 million
- Year 4: $2 million
- Year 5: $1.5 million
- Year 6: $1 million

Actual funding levels will depend on the availability of funds.

Applications with proposed budgets that exceed the maximum allowed in any year (e.g., $1 million in Year 1, $1.5 million in Year 2, $2.5 million in Year 3, $2 million in Year 4, $1.5 million in Year 5, and $1 million in Year 6) will be returned without review.

Awards may be requested for up to 6 years. Annual continuation awards will depend on the availability of funds and the progress achieved.

Cost Sharing

By statutory mandate, this program requires the applicant entity to provide, directly or through donations from public or private entities, nonfederal contributions:

- For the first, second, and third fiscal years of the cooperative agreement, the awardee must provide at least $1 for each $3 of Federal funds;
- For the fourth fiscal year, the awardee must provide at least $1 for each $1 of Federal funds; and
- For the fifth and sixth fiscal years, the awardee must provide at least $2 for each $1 of Federal funds.

Matching resources may be in cash or in-kind, including facilities, equipment, or services, and must be derived from nonfederal sources (e.g., State or sub-State nonfederal revenues, foundation grants).

It is expected that nonfederal match dollars will include contributions from various child-serving systems (e.g., education, child welfare, juvenile justice). The applicant should specify the names of the expected

sources, the types of sources (e.g., education, child welfare, juvenile justice), and the amounts of matching funds, as evidence of the project's potential to sustain itself beyond the 6-year award period.

There is concern that the Federal funds for this program might be used to replace existing nonfederal funds. Therefore, applicants may include nonfederal match contributions in excess of the average amount of nonfederal funds available to the applicant public entity over the 2 fiscal years preceding the fiscal year when the Federal award is made. Nonfederal public contributions, whether from State, county, or city governments, must be dedicated to the community (ies) served by the cooperative agreement.

A letter from the director of the State, county, or city mental health agency applying for the cooperative agreement should certify that nonfederal matching funds for the proposed project are available. The letter must be included in Appendix No. 5 of the application entitled, Nonfederal Match Certification. Such letter also should indicate that proposed changes in funding streams required for the match or other funding innovations necessary for implementation of the proposed project will be allowed. Additional letters from other nonmental health agency directors (e.g., education, child welfare, juvenile justice) at the State, county, or city levels, also may be included in Appendix No. 5 of the application.

Indian tribes receiving funds under the Self-Determination and Education Assistance Act, PL 93-638, as amended, are exempt from the restriction that prohibits the use of those Federal funds as a match.

Who Can Apply?

Eligibility for this program is statutorily limited to public entities such as:

- State governments;
- Indian tribes or tribal organizations (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination and Education Assistance Act);
- Governmental units within political subdivisions of a State, such as a county, city, or town;
- District of Columbia government; and
- Government of the Territories of Guam, Commonwealth of Puerto Rico, Northern Mariana Islands, Virgin Islands, American Samoa, and Trust Territory of the Pacific Islands (now Palau, Micronesia, and the Marshall Islands).

A new cooperative agreement application must specify a geographic service area within the State, county, tribe, or territory that is different from the geographic area of current awards.

An exception to this requirement will be made specifically for States whose previous award(s) were to develop systems of care across the entire State. Such States with a previous statewide implementation approach may apply for this cooperative agreement, as long as any previous awards under this program have expired in their entirety, including their no-cost extension years. See Appendix G for a list of current and past funding recipients, including the county areas in which each of these funded systems of care has been implemented.

The legislation specifies only one

application per public entity. However, a State, county, city, tribal, or territorial government may apply simultaneously for separate cooperative agreements within a State,
as long as the geographic area specified in a cooperative agreement application does not overlap with the geographic area specified in another cooperative agreement application within the same State.

Public entities that have not been funded previously are encouraged to apply. States not previously funded through FY 2002 include Arkansas, Iowa, Louisiana, and Montana.

Eligible applicants must meet the following requirements:

- The application only may be submitted by the Office of the Governor, or by the chief executive officer of a tribe, Territory, or the District of Columbia. However, it also may be submitted by the chief executive officer of a State agency, State political subdivision (e.g., county, city), Indian tribe, tribal organization, or Territory, as long as this person is specifically designated in writing by the governor or by the chief executive officer of a tribe, territory, or the District of Columbia to submit this application.

- As an indicator of potential sustainability, the applicant public entity must include a letter of assurance from the governor of the State or Territory, or the governor's designee, stating that the public entity will provide directly any service required in this cooperative agreement, which is also covered in the State Medicaid Plan, and that it has entered into a participation agreement under the State plan and is qualified to receive payments under such plan. If the public entity will not provide direct services, then the letter of assurance must indicate that the public entity will enter into an agreement with an organization that will provide the service, and the organization has entered into a participation agreement under the State Medicaid Plan and is qualified to receive Medicaid payments.

  In addition, the letter of assurance from the governor or the governor's designee must indicate that the system of care proposed under this Request for Applications (RFA) is specifically included in the goals of the State's or Territory's Community Mental Health Services Block Grant Plan, as authorized in Section 564 (b) of the PHS Act, and in the state or territory's Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances, submitted under Public Law (PL) 102-321. If the proposed system of care is not included in these State or Territory plans, the letter of assurance should indicate that it will be included in a revision of the plan at its next renewal date.

  This letter of assurance from the governor or the governor's designee is not required of Indian tribes or tribal organization applicants.

  The letter of assurance must appear in Appendix No. 2 of the application entitled, "Governor's Assurance." The governor may use this same letter to designate the chief executive officer of the public entity who will sign and submit the application. **If this letter does not appear in the appendix, the application will not be reviewed.** See Table 1 on page 6 for a summary

of eligibility requirements.

Table 1: Summary of Eligibility Requirements					
Eligible Applicant	Requirement	Signature on Application	Letter of Assurance	Expected Number of Awards	Expected Funding Amount
State government	Eligible if targeted to a new geographic area; proposed geographic area may not overlap with geographic area in application from a political subdivision of the State. Exception: If applicant was previously awarded a grant for the entire State, such applicant may be eligible, as long as previous award has expired, including any no-cost extension year.	Governor or chief executive officer of State agency, designated in writing by the governor.	Yes	5 - FY 2003 5 - FY 2004	
Counties, cities, Territories	Eligible if targeted to a new geographic area; proposed geographic area may not overlap with geographic area from any other concurrent application within the State or Territory.	Chief executive officer, designated in writing by the governor or by the chief executive of a Territory or the District of Columbia.	Yes		$5 million - FY 2003 $5 million - FY 2004
Tribe	Eligible only if targeted to a new Tribe or tribal organization.	Tribal leader or Tribal council	No		

Application Kit

The application kit for this RFA includes:

1. ***PHS 5161-1 (revised July 2000)*** **-** This form includes the Face Page, Budget Forms, Assurances, Certifications, and Checklist.

2. ***Part I*** **-** This part includes instructions that are specific to this cooperative agreement. This document is Part I of the application kit.

3. ***Part II*** - This part provides general guidance and policies for SAMHSA grant applications. The policies in Part II that apply to this program are listed in this document under "Special Considerations and Requirements."

You must use all of the above documents in the kit in completing your application.

How to Get an Application Kit

Call 800-789-2647: Be prepared to provide the name of the RFA ("Child Mental Health Initiative") and the RFA number ("SM-03-009") when ordering.

Download from the web site: You may download ***Part I, Part II, and the PHS Form 5161-1*** of the application kit from the SAMHSA web site at www.samhsa.gov. Click on "Grant Opportunities" and then "Current Grant Funding Opportunities."

Write to: National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015

Please indicate with the request that you are ordering the application kit for the **Child Mental Health Initiative, RFA No. SM-03-009.** Only one application kit per request will be sent.

Where to Send the Application

Send the original and two copies of your cooperative agreement application to:

Mr. Ray Lucero
Review Branch
Substance Abuse and Mental Health Services Administration
Parklawn Building, Room 17-89
5600 Fishers Lane
Rockville, MD 20857
Attn: Announcement No. SM-03-009

All applications MUST be sent via a recognized commercial or governmental mail carrier. Hand-carried applications will not be accepted. **Applications sent via fax or e-mail will not be accepted. You will be notified by letter that your application has been received.**

Be sure to type the RFA No. and Title, "***SM -03-009*** Cooperative Agreements for the Child Mental Health Initiative" in Item Number 10 on the face page of the PHS 5161-1 application form.

If you are required by your mail carrier to indicate a phone number for delivery, you may use (301) 435-9917.

Application Due Date

Your application must be received by either one of two receipt dates:

1) August 5, 2003, or

2) October 15, 2003.

Applications received after either one of these dates will be accepted only if they have a legible proof-of-mailing date from the carrier of no later than July 29, 2003 (for August 5th applications), or October 8, 2003 (for October 15th applications).

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on *program issues*, contact:

Rolando L. Santiago, Ph.D. or
Diane L. Sondheimer, M.S., M.P.H.
Child, Adolescent and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 11C-16
Rockville, MD 20857
(301) 443-1333
E-mail: *rsantiag@samhsa.gov*
dsondhei@samhsa.gov

For questions on *grants management issues*, contact:

Steve Hudak
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
5515 Security Lane, Rockwall II, Room 630
Rockville, MD 20852
Phone: (301) 443-9666
E-mail: shudak@samhsa.gov

Technical Assistance Teleconference Calls

SAMHSA/CMHS intends to sponsor 10 2-hour and 30-minute teleconference calls to provide technical assistance on the preparation of applications. The calls will be scheduled on eastern daylight time, as follows, for the August 5 submission date:

June 24, 2003:
- 10:30 a.m. - 1:00 p.m. (Part I for Midwestern and Eastern states and Atlantic territories)
- 4:00 - 6:30 p.m. (Part I for Western states and Pacific territories)

June 26, 2003:
- 10:30 a.m. - 1:00 p.m. (Part II for Midwestern and Eastern states and Atlantic territories)
- 4:00 - 6:30 p.m. (Part II for Western states and Pacific territories)

June 27, 2003:
- 1:00 - 3:30 p.m. (Implications of Part I and II for tribes and tribal organizations)

For the October 15 submission date, the calls will be scheduled on eastern daylight time as follows:

September 9, 2003:
- 10:30 a.m. - 1:00 p.m. (Part I for Midwestern and Eastern states and Atlantic territories)

- 4:00 - 6:30 p.m. (Part I for Western states and Pacific territories)

September 11, 2003:
- 10:30 a.m. - 1:00 p.m. (Part II for Midwestern and Eastern states and Atlantic territories)
- 4:00 - 6:30 p.m. (Part II for Western states and Pacific territories)

September 12, 2003:
- 1:00 - 3:30 p.m. (Implications of Part I and II for tribes and tribal organizations)

In addition, technical assistance materials on topics that include RFA overview, nonfederal contributions, family involvement, cultural competence, and others will be available on the www.samhsa.gov web site on June 15, 2003.

Cooperative Agreements

This award is being made as a cooperative agreement, because it will require substantial Federal staff involvement.

Awardees must:

- Comply with the terms and conditions of the agreement, which will be specified in the Notice of Grant Award (NOGA).

- Agree to provide SAMHSA with data required for the Government Performance and Results Act (GPRA), which can be done through participation in the National Evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families.

SAMHSA Staff will:
- Monitor each awardee's progress in the implementation of program requirements.

- Review and approve each stage of project implementation.

- Participate in making decisions with the awardee to help achieve project objectives.

- Approve decisions of each awardee about:

  - Use of technical assistance resources for developing the system of care, according to requirements of the cooperative agreement, and for increasing the likelihood that the system of care will be sustained beyond the Federal funding period;

  - Use of communications, public awareness, and social marketing techniques in the community to promote good mental health practices among children and youth with serious emotional disturbances and their families; advertise systems-of-care services and reduce community-wide stigma associated with serious emotional disturbances;

  - Ways to insure implementation of the National Evaluation to: (1) demonstrate the effectiveness of each system of care through evidence that the well-being of children with serious emotional disturbances and their families increases as a result of receiving systems-of-care services; (2) ensure timely submission of data to the National Evaluation contractor; (3) use data to improve and sustain the system of care; and (4) ensure that the capacity for evaluation continues beyond the Federal funding period.

- Conduct formal Federal site visits in Years 2 and 4 of the cooperative agreement, or, more frequently, as needed, and informal site visits as needed.

- Ensure that systems-of-care activities under this program are coordinated with CMHS, SAMHSA, and other Federal initiatives, as appropriate.

The Government Project Officer (GPO) will:

- Manage the negotiation, award, financial, and other administrative aspects of assigned cooperative agreements. The GPO utilizes information from Federal site visits, quarterly progress reports, re-application forms, technical assistance and National Evaluation reports, phone calls, e-mail messages, and other appropriate means to help make decisions with the awardees.

- Be responsible for ensuring that the project is operated in compliance with applicable Federal laws, regulations, and guidelines and the terms and conditions of the award. The GPO works with the Grants Management Officer to respond to questions about regulations and policies that apply to this cooperative agreement and to answer requests for required prior approval.

Award Criteria

Decisions to fund a cooperative agreement under this announcement are based on:

1. The strengths and weaknesses of the application, as determined by the Peer Review Committee and approved by the CMHS National Advisory Council.

2. Availability of funds.

Post-award Requirements

Upon receipt of a cooperative agreement award, the awardee must:

1. Comply with the terms and conditions negotiated for the award.

2. Provide, at a minimum, the following reports:

    1. Quarterly reports.

    2. Annual report (in place of fourth quarterly report) summarizing project progress, problems, and alterations in approaches. This report will be used to determine whether the awardee has achieved project goals and will be eligible for a noncompetitive renewal.

    3. Final report at the end of the 6-year project period summarizing progress, problems, and alterations in approaches.

Program Overview

This program overview includes statements about the background, program goals, target population, program requirements, allowable items of expenditure, limitations on imposition of fees for services, administrative costs, and other costs.

Background

For background and a history of systems of care, which was influential in the creation of the Comprehensive Community Mental Health Services Program for Children and Their Families, please see Appendix C.

Program Goals

The statutory goal of the program is to award Federal funds to public entities to provide comprehensive community mental health services to children with a serious emotional disturbance. The goal can be carried out only by operating one or more systems of care as described in the Definitions Section of this RFA (see Appendix A).

The statute further requires that evaluations of systems of care carried out under the program include longitudinal studies of the outcomes of services provided by such systems. These evaluations are conducted by awardees, in collaboration with a CMHS National Evaluation contractor, to assess the effectiveness of systems of care.

In brief, the primary goals of the program are to:

1. Develop systems of care for children with a serious emotional disturbance and their families.

2. Provide a broad array of mental health and other related services, treatments, and supports to the target population.

3. Evaluate the effectiveness of the system of care and its component services.

4. Involve families in the development of the system and the services, and in the care of their own children.

5. Incorporate culturally competent practices for serving children and their families from racial and ethnic populations represented in each funded community.

Target Population

Children and adolescents with a serious emotional disturbance are eligible for services provided under this program if they meet the following criteria:

Age. Are from birth to 21 years of age.

Diagnosis. Have an emotional, behavioral, or mental disorder diagnosable under *DSM-IV* or its *ICD-9-CM* equivalents, or subsequent revisions (with the exception of *DSM -IV* "V" codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder). For children 3 years of age or younger, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:03)* should be used as the diagnostic tool. (See www.zerotothree.org for more information.) For children 4 years of age and older, the *DISC* may be used as an alternative to the *DSM-IV*.

Disability. Are unable to function in the family, school, or community, or in a combination of these settings. (Awardees must define level of functioning required for eligibility.)

Or, the level of functioning is such that the child or adolescent requires multiagency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, and primary health care.

For children under 6 years of age, community service agencies include those providing services in the areas of child care, early childhood education (e.g., Head Start), pediatric care, and family mental health. For youth ages 18 to 21, community service agencies include those providing services in the areas of adult mental health, social services, vocational counseling and rehabilitation, higher education, criminal justice, housing, and health.

Duration. Have a disability that must have been present for at least 1 year, or, on the basis of diagnosis, severity, or multiagency intervention, be expected to last more than 1 year.

Youth with a co-occurring serious emotional disturbance and substance use disorder. This program also is concerned about youth with a serious emotional disturbance, who may have a co-occurring substance abuse problem. Evidence from the National Evaluation of the program suggests that nearly 50 percent of adolescents receiving services through the funded systems of care have a co-occurring serious emotional disturbance and a substance use disorder. The degree of the problem also suggests that the program should address the substance abuse treatment needs among these adolescents. In addition, cooperative agreements funded under this program are encouraged to use the "window of opportunity" during the pre-adolescent years to provide effective substance abuse prevention interventions for children identified with a serious emotional disturbance, such as those promoted through the National Registry of Effective Practices (NREP) of SAMHSA's Center for Substance Abuse Prevention. (See www.samhsa.gov.)

Infants and young children with a serious emotional disturbance. There is growing recognition that infants and young children from birth to 5 years of age also suffer from serious emotional disturbances and that the needs of these children and their families are not adequately being met. Many of the former and current grantees of the program focused their efforts on developing systems of care for children between the ages of 6 and 17. Applicants for this cooperative agreement are encouraged to propose systems of care that also serve children from birth to age 5.

Young adults with a serious emotional disturbance. Young adults, from ages 18 to 21 with a serious emotional disturbance, represent a group that child and adult mental health systems have not been able to serve adequately in the past. This is due, in part, to the lack of careful coordination among children's services and adult services in many of the traditional human service sectors such as mental health, social services, education, criminal justice, and health care. Applicants are encouraged to propose systems of care that deliver services to young adults ages 18 to 21 and that coordinate services and supports among appropriate human service agencies for this age group.

Program Requirements

Appendix B: Program Requirements for the Development of Systems of Care describes the requirements of the Center for Mental Health Services for developing a system of care through this cooperative agreement. These requirements include those mandated in Section 561-565 of the Public Health Service Act, as amended.

The applicant must have a thorough understanding of these requirements before writing the Project Narrative of this application. The Project Narrative instructions refer directly to the requirements and guidance in Appendix B.

Successful applications will be those which best address the requirements and guidance in Appendix B.

Allowable Items of Expenditure

Cooperative agreement funds may be used for the costs of planning, implementing, and evaluating the project. These costs include:

1) Salaries, wages, and fringe benefits of the project director and other support staff who are engaged in project activities. (Support from the cooperative agreement for salaries and wages of staff that are engaged less than full time in activities supported by the cooperative agreement must be commensurate with the effort provided under the cooperative agreement).

2) Travel directly related to carrying out activities under the approved project.

3) Office supplies and equipment and rental of space directly related to approved project activities.

4) Contracts for performance of project activities such as implementation of required mental health services, interagency coordination, evaluation, and communications.

5) Training activities as specified in Appendix B: Program Requirements for the Development of Systems of Care.

6) Other approved activities necessary to support the development of the project, so long as they are allowable under applicable cost principles.

Federal funds, and the nonfederal contributions made with respect to the grant, will **not** be expended for:

- Nonmental health services, including medical services, educational services, vocational counseling and rehabilitation, and protection and advocacy.

- The purchase, renovation, or construction of facilities to house any portion of the proposed project. Any lease arrangements associated with the proposed project that utilizes Public Health Service (PHS) funds may not be awarded by the PHS beyond the project period, nor may the portion of the space leased with PHS funds be used for purposes not supported by the cooperative agreement.

- Room and board in any residential setting (including therapeutic foster homes or group homes) serving 10 or more children.

- Room and board or other services or expenditures associated with the care of children in residential breakout centers serving more than 10 children, or in inpatient hospital settings, except intensive home-based services and other services provided on an ambulatory or outpatient basis.

- Training of any individual, except training in: 1) the administration of the system of care; 2) the provision of intensive home-based services; 3) intensive day treatment; 4) foster care or group homes; and 5) the development of individualized plans.

Limitations on Imposition of Fees for Services

If a charge is imposed for the provision of services funded under the cooperative agreement, such charge:

- Will be made according to a schedule of charges that is made available to the public;
- Will be adjusted to account for the income level of the family of the child involved; and
- Will not be imposed on any child whose family has an income and resources equal to or less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary, in accordance with Section 673 (2) of the Omnibus Budget Reconciliation Act of 1981.

Administrative Costs

Section 564 (e) of the Public Health Service Act states that no more than 2 percent of each cooperative agreement is to be used for administrative expenses incurred by the awardee.

Other Costs

Applicants are required to budget for attendance of a core team of approximately 10 individuals at three 3-day meetings per year to create a learning community among all awardees. The learning community will: (1) provide the most recent information about best practices, policy trends, and research findings on systems of care; (2) provide innovative training, technical assistance, and educational experiences that will directly contribute to developing and sustaining systems of care; (3) discuss improvements in systems-of-care practices, based on the most recent findings from the National Evaluation and other related research studies; and (4) assist with the development of strategic plans for the national program and for each funded community.

The core team must include the project director, evaluator, key family contact, clinical director, youth coordinator, technical assistance coordinator, communications manager, representatives from at least two other child-serving systems in the community, and the State contact for the project.

What to Include in Your Application

For your application to be **complete and eligible**, it must include the following in the order listed. Check off areas as you complete them for your application.

☐ **1. FACE PAGE**

Use Standard Form 424 (SF-424), which is part of the PHS 5161-1. See Appendix A in Part II of the RFA for instructions. When you sign the face page of the application, you agree that the information is accurate and complete.

☐ **2. ABSTRACT**

Your total abstract may not be longer than 35 lines. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reports to Congress, or press releases.

❑ **3. TABLE OF CONTENTS**

Include page numbers for each of the major sections of your application and for each appendix.

❑ **4. BUDGET FORM**

Standard Form 424A (SF-424A), which is part of the PHS 5161-1, is to be used for the budget. Fill out sections B, C, and E of the SF 424A. Follow instructions in Appendix B of Part II of the RFA.

❑ **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

The Project Narrative describes your project. It consists of Sections A through D. The total number of pages for Sections A-D may not exceed 35.

☐ **Section A -** Understanding of the Project

☐ **Section B -** Implementation Plan

☐ **Section C -** Project Management and Staffing Plan

☐ **Section D -** Evaluation Plan

The Supporting Documentation section of your application provides additional information necessary for the review of your application. This Supporting Documentation should be provided immediately following your Project Narrative in Sections E through H.

There are no page limits for the following sections, except for Section G, the Biographical Sketches and Job Descriptions.

☐ ***Section E - Literature Citations***. This section must contain a complete list of literature citations that appear in your application. Each citation should include, at a minimum, the title, author(s), and year when the piece of literature was published.

☐ ***Section F - Budget Justification, Existing Resources, Other Support***. You must provide a narrative justification for the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. (See *Part II of the RFA, Example A, Justification*.) The budget must include the proposed amounts of nonfederal match contributions for each of the 6 years of the project.

☐ ***Section G - Biographical Sketches and Job Descriptions***. Include a biographical sketch for key personnel, including the project director, clinical director, evaluator, and key family contact. Each sketch should be no longer than **two pages**. If the person has not been hired, include a letter of commitment from the individual, with a current biographical sketch.

- Include job descriptions for key personnel, including the project director, clinical director, evaluation director, and key family contact. Also include job descriptions for the youth coordinator, technical assistance coordinator, communications manager, State and local agency liaison, other evaluation staff who will assist the evaluation director, and any key consultant(s). These job descriptions should not be longer than **one page each**.

  - **Sample sketches and job descriptions are listed on page 22, Item 6, in the Project Narrative section of the PHS 5161-1.**

☐ ***Section H - SAMHSA's Participant Protection (SPP).*** The elements you

need to address in this section are described after the Project Narrative section of this document.

❑ **6. APPENDICES 1 THROUGH 6**

- Use only the appendices listed below.
- **Do not** use appendices to extend or replace any of the sections of the Project Narrative. (Reviewers will not consider them if you do.)
- **Do not** use more than **50 pages** for the appendices. One copy of each data collection instrument should be included within these pages.

Appendix 1: Memoranda of Understanding for Services Coordination and Evaluation

Appendix 2: Governor's Assurance

Appendix 3: Data Collection Procedures

Appendix 4: Sample Consent Forms

Appendix 5: Non-Federal Match Certification

Appendix 6: Organizational Chart, Staffing Pattern, Timeline, and Management Chart

❑ **7. ASSURANCES**

Nonconstruction Programs. Use Standard Form 424B (SF-424-B) found in PHS 5161-1.

❑ **8. CERTIFICATIONS**

Use the "Certifications" forms, which can be found in PHS 5161-1. See Part II of the RFA for instructions.

❑ **9. DISCLOSURE OF LOBBYING ACTIVITIES (See form in PHS 5161-1.)**

Appropriated funds, other than for normal and recognized executive/legislative relationships, may not be used for lobbying the Congress or State legislatures. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grassroots" lobbying, which consists of appeals to members of the public suggesting they contact their elected representatives to indicate their support for or opposition to pending legislation, or to urge those representatives to vote in a particular way. (Please read ***Part II*** of the RFA, General Policies and Procedures for all SAMHSA applications, for additional details.)

❑ **10. CHECKLIST** (found in the PHS 5161-1 Form)

You must complete the Checklist. See ***Part II,*** Appendix C, of the RFA for instructions.

Project Narrative – Sections A through D

Use the instructions below that are specific to the Comprehensive Community Mental Health Services Program for Children and Their Families. These are to be used instead of the Program Narrative instructions found on page 21 of the PHS 5161-1 document. Responses to Sections A through D represent the Project Narrative of your application. Below are instructions on how to respond to Sections A through D.

Responses to these sections may not be longer than 35 single-spaced typewritten pages.

- A committee will review and score your application, based on the requirements described below for Sections A through D. These requirements also will serve as review criteria for the review committee.

- A peer review committee will assign a total point value to your application, based on how well you respond to each of the sections.

- The number of points indicated after each section heading shows the maximum number of points the review committee will assign to your responses for that section.

  Statements indicated by a bullet provide instructions for developing a response to each section, but no points are assigned specifically to each of these bullet statements.

- Reviewers also will be looking for evidence of cultural competence in each section of the Project Narrative. Points will be assigned based on how well you address cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in *Part II* of the RFA, Appendix D.

Section A: Understanding of the Project
(15 Points)

This section should demonstrate an understanding of systems of care, and especially address the significance of developing systems of care in the proposed geographic service area.

- Provide a brief literature review, which demonstrates:

  - Knowledge of the principles of systems of care for children with a serious emotional disturbance. (See Appendix A: Definitions Section.);
  - Knowledge of the history of systems of care in the United States; and
  - Need for systems-of-care reform in this country, and specifically, in the targeted community.

(List in Section E the literature citations you reference in your application.)

- Describe the population of children with a serious emotional disturbance in the geographic service area that will be targeted by the project. Include in this description:

  - Projected age range (e.g., birth to 21, 5 to 17);
  - Prevalence estimate (in numbers) of children with a serious emotional disturbance within the geographic service boundaries of the project;
  - Estimated percentages of children, and their families, from racial and ethnic groups represented in the geographic service area;
  - Other demographic characteristics of children and their families such as gender, family income levels, level of disability, and literacy levels;
  - Family or institutional settings in which these children live or are currently served (e.g., special education programs, foster care, probation), and which will be potential sources of referrals. Include expected number of referrals from each source; and
  - Primary language, level of acculturation, migration and

immigration characteristics, and service disparities for children from racial or ethnic minority groups. Service disparities may be indicated through differential racial or ethnic rates of out-of-home or out-of-State placements, representation in juvenile justice facilities, or representation in restrictive mental health treatment settings. Disparities also may be indicated in differential rates of racial or ethnic access to quality care.

- Describe the current capacity to serve children with a serious emotional disturbance and their families. Specifically, describe the existing resources and services available within the jurisdiction of the proposed project. If possible, try to estimate the number of children currently served.

- Establish the significance of the proposed project by identifying the gaps in, inadequacies of, and barriers to current service structures that justify the need for the proposed project.

- Describe how the proposed project also will collaborate with other Federal, State, and local programs and reform initiatives. (See Appendix B, Section 2 - Services Provision, for a listing of relevant Federal programs.)

Section B: Implementation Plan
(45 Points)

Use Appendix B: Program Requirements for the Development of Systems of Care as a guide for developing the implementation plan required in this section. Specifically:

- Indicate the primary goals and objectives of the project.

- Describe how the infrastructure for the system of care will be developed.

  Include the approach for developing the procedures for systems integration, interagency collaboration, services integration, wraparound processes, care review, access, financing, workforce development, and community leader support.

  Also, describe a plan for replication of the local systems-of-care model in other communities of the State, tribe, or territory. Indicate how the local system of care is fiscally integrated into statewide, tribal, or territorial policy initiatives such as the Mental Health Plan for the State, tribe, or territory, as well as the State or territorial Mental Health Block Grant Plan.

  Include the approach and strategies for developing the structures of a system-of-care such as the clinical network, governance body, administrative team, training capacity, performance standards, management information system, and office in the community.

- Explain how the service provision components of the system of care will be developed in your project. Include how the following services will be implemented throughout the 6-year period:

  - Required mental health services and supports;
  - Optional services; and

- Nonmental health services.

  Among the nonmental health services, the applicant must specify programmatic and fiscal strategies for incorporating into the individualized service plan: (1) substance abuse treatment services for adolescents with a co-occurring serious emotional disturbance and substance use disorder; (2) substance abuse prevention interventions for pre-adolescents with a serious emotional disturbance; (3) medical services for children with a co-occurring serious emotional disturbance and chronic illness; and (4) literacy interventions specific for children with a serious emotional disturbance.

- Describe the strategies to implement key service activities including:

  - Clinical interventions;
  - Care management services; and
  - Individualized service plans.

  The applicant should specify one or more evidence-based clinical interventions it intends to implement within the array of systems-of-care services. There also should be a description of how these evidence-based interventions will become integrated into the individualized service plan and wraparound process for children with a serious emotional disturbance for whom the evidence-based interventions apply.

- Explain how family involvement, youth involvement, and cultural competence will be applied within the system of care throughout the 6-year period.

- Describe the training, technical assistance, and social marketing strategies that will be used to support the development of the system of care. *(Do not describe evaluation activities in this section, but please do so in Section D.)*

- Explain how the project will increase the capacity and quality of services delivered to children with a serious emotional disturbance. State the number of children expected to be served annually in the system of care and the number of children to be served through specific key services such as care management, intensive home-based services, crisis intervention, day treatment, therapeutic foster care, and respite care.

- Specify eligibility criteria, referral sources, and enrollment procedures that will be used for creating efficient access into systems-of-care services.

- Describe how the following individuals have participated in the development of the implementation plan contained in this application:

  - Representatives of State and local child-serving agencies and community leaders;
  - Family members and representatives of family-run organizations;
  - Representatives of racial or ethnic minority groups in the community. Such racial or ethnic representatives may include youth from the target population, family members, service providers, or community leaders.

- Discuss the extent to which nonfederal match dollars demonstrate interagency collaboration through contributions from different child-serving agencies.

- Discuss strategies for ensuring project

sustainability after the sixth year of the cooperative agreement through amounts and sources of nonfederal match contributions. Please indicate the extent to which services provided through the system of care will be paid through Medicaid and other public or private insurance.

Section C: Project Management and Staffing Plan
(25 Points)

The management and staffing plan must be clearly explained in this section. Please include the following in the plan:

- A brief description of the applicant organization and its relationship to other child- and family-serving organizations. Please include an organizational chart in Appendix 6 of the application. Memoranda of understanding with any collaborating agencies and organizations must be provided in Appendix 1 of the application.

- The qualifications and experience of key personnel, including:

  - Principal investigator;
  - Project director;
  - Clinical director;
  - Key evaluation staff;
  - Key family contact;
  - Youth coordinator;
  - Technical assistance coordinator;
  - Communications manager;
  - State and local agency liaison; and
  - Key consultants.

  See Appendix F for a description of several of these key staff persons.

  - The percentage of time that each person will dedicate to the project. Provide a rationale for the dedicated time of each person. Include a staffing pattern chart in Appendix 6 of the application.

- A description of the tasks to be performed and their relationship to the project goals and objectives. The staff position responsible for implementing each task should be identified. Include a management chart in Appendix 6.

- A timeline of activities and tasks that will be implemented each year of the 6-year Federal funding period. Discuss the feasibility of accomplishing the proposed sequence of activities and tasks specified in the timeline. Please include the timeline in Appendix 6.

(The charts for the above management plan and activities timeline can be incorporated into one chart and included in Appendix 6.)

- A description of the facilities, equipment, and resources (e.g., management information system, office space, computer networks) available for the project.

- Evidence that the services are provided in a location that is accessible, compliant with the Americans with Disabilities Act (ADA), and culturally appropriate for the children and families who will be served.

- Evidence that the practices for protecting the privacy of children and families served through the system of care, as well as the practices for reimbursement of services through electronic transmission of invoices and payments, are compliant with standards of the

Health Insurance and Portability Accountability Act (HIPAA).

Section D: Evaluation Plan
(15 Points)

Use the description of evaluation activities in Section 5 of Appendix B, Program Requirements for the Development of Systems of Care, to prepare the evaluation plan. The evaluation plan should:

- Describe the evaluation activities and procedures that will ensure successful implementation of the National Evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families.

- Describe how data derived from the National Evaluation will be used for:

  - Improving the service system,
  - Increasing the quality of service delivery,
  - Developing systems of care policies in the local community, and
  - Sustaining the system of care beyond the 6-year period of Federal funding.

- Describe the knowledge and experience of individuals with evaluation expertise who are available from local universities or the community, and especially address how you intend to obtain and use the expertise of these individuals for implementation of evaluation activities. Specify the degree to which these individuals have specialized knowledge and experience about:

  - Applied research and evaluation methods, especially longitudinal study techniques, as well as family and community study approaches;
  - Children's mental health services;
  - Direction and supervision of research and evaluation projects; and
  - Writing and reporting of research and evaluation findings in peer-reviewed journals, and also among multiple public audiences, including family members, policy makers, administrators, and clinicians.

- Describe the facilities, equipment, materials, and resources that will be dedicated to evaluation activities. Include a description of the data management, spreadsheet, and statistical software available to the project.

- Describe how the project staff will perform the functions of data entry, storage, management, analysis, and reporting. Indicate how completed surveys and records will be kept secure and confidential.

- Provide a detailed description of the type of administrative and service utilization data currently available in management information systems (MIS), and indicate the child-serving agencies which have already developed these MIS. Also, discuss the feasibility of creating one integrated MIS among the collaborating child-serving agencies.

- Explain how family members and youth will be incorporated into evaluation activities. These activities may include providing feedback on the design and objectives of the evaluation, conducting interviews, analyzing data, and interpreting and reporting results.

- Describe the nature of any local evaluation activities that will be

implemented, in addition to the required activities for implementing the National Evaluation.

- Indicate the institution which will approve an Institutional Review Board (IRB) application for protection of human subjects after the cooperative agreement award is made. This IRB application will include data collected through the National Evaluation and any local evaluation efforts.

NOTE: Although the budget for the proposed project is not a review criterion, the review committee will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SAMHSA Participant Protection Requirements

Part II of the RFA provides a description of SAMHSA's Participant Protection Requirements.

SAMHSA will place restrictions on the use of funds until all participant protection issues are resolved. Problems with participant protection identified during peer review of your application may result in a delay of funding.

You must address each element regarding participant protection in your supporting documentation. If any one or all of the elements is not relevant to your project, you must document the reasons why the element(s) does not apply.

(Please refer to the required procedures for the National Evaluation described in Section 5 of Appendix B of this RFA for responding to this section. Also, refer to additional procedures included in any local evaluation efforts of your project.)

This information will:

1. Reveal if the protection of participants is adequate or if more protection is needed.

2. Be considered when making funding decisions.

Projects may expose people to risks in many different ways. In this section of your application, you will need to:

- Identify and report any possible risks for participants in your project;

- State how you plan to protect participants from those risks; and

- Discuss how each type of risk will be dealt with or why it does not apply to the project.

Each of the following elements must be discussed:

❶ Protection of Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.

- Discuss risks that are due either to participation in the project itself or to the evaluation activities.

- Describe the procedures that will be followed to minimize or protect participants against potential risks,

including risks to confidentiality.

- Give plans to provide help if there are adverse effects on participants.

❷ Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background, and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or those who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

❸ Absence of Coercion

- State whether participation in the project is voluntary or required. Identify possible reasons why it is required, such as court orders requiring people to participate in the program.

- If you plan to pay participants, state how participants will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services, even if they do not complete the study.

❹ Data Collection

- Identify from whom you will collect data. Examples include participants themselves, family members, teachers, and others. Describe the data collection procedure, and specify the sources for obtaining data. Examples include school records, interviews, psychological assessments, questionnaires, observations, or other sources. Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what types of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation, or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix No. 3, "Data Collection Instrument/Interview Protocols," copies of all available data collection instruments and interview protocols you plan to use.

❺ Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, such as using a coding system on data records, limiting access to records, or storing

identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records, according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

❻ Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - Whether or not their participation is voluntary;
  - Their right to leave the project at any time without problems;
  - Possible risks from participation in the project; and
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social, or other risks, you **must** get written, informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms." If needed, provide translations of the English versions of consent forms.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

❼ Risk/Benefit Discussion

- Discuss why the risks are reasonable, compared to the expected benefits and importance of the knowledge from the project.

Special Considerations and Requirements

SAMHSA's policies, special considerations, and requirements related to grants and cooperative agreements are found in Part II

of the RFA. The policies and special considerations that apply to this program are:

- Government Performance and Results Act (GPRA)
- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2000
- Consumer Bill of Rights and Responsibilities
- Promotion of the Nonuse of Tobacco
- Supplantation of Existing Funds
- Letter of Intent
- Single State Agency Coordination
- Intergovernmental Review (E.O. 12372)
- Confidentiality/SAMHSA Participant and Human Subjects Protections

The Application and Review Procedures that apply to this program are:

- Application Instructions
- Application Components
- Terms and Conditions of Support
- Allowable Items of Expenditure
- Alterations and Renovations
- Reporting Requirements
- Lobbying Prohibitions

Appendix A

Definitions Section

Community

For the purpose of this program, community is any discrete geographic entity that is defined by the applicant. The scope and size of the community is left to State or local discretion. States and non-State applicants may choose to create systems in communities as small as a single school district or as large as an area comprising a county or a group of contiguous counties. A State with a sparse population may wish to develop a system to cover the entire State, but it is expected that this will be the exception. The amount of funds requested through the cooperative agreement should be proportional to the number of children in the community, and applicants should ensure that sufficient funds are requested and available to develop a comprehensive system of care with sufficient service capacity in the designated target community.

System of Care

For the purpose of this program, system of care is defined as a comprehensive spectrum of mental health and other support services, which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such systems of care involves a multiagency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, adolescents, and their families. Mechanisms for managing, coordinating, funding, and evaluating services are necessary.

The system-of-care concept developed through the federal Child and Adolescent Service System Program (CASSP) in the 1980's is based upon the core values that the system of care should be child-centered and family-focused and that it should be community-based. In addition, the following set of guiding principles, articulated in the CASSP monograph, ***A System of Care for Children and Youth with Severe Emotional Disturbance***, by Stroul and Friedman (1986, 1994), represent a clear philosophy about the way in which services should be delivered to youngsters and their families. Children and adolescents with serious emotional disturbances and their families should:

- Have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

- Receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan.

- Receive services within the least restrictive, most normative, environment that is clinically appropriate.

- Receive services that are integrated, with linkages between child-caring agencies and

programs and mechanisms for planning, developing and coordinating services.

- Be provided with care management or a similar mechanism to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

- Be able to participate in family/professional partnerships in all aspects of the planning, implementation, delivery management, and evaluation of the service delivery system responsible for serving their children.

- Be provided with early identification and intervention by the system of care in order to enhance the likelihood of positive outcomes.

- Be ensured of a smooth transition to adulthood and to the adult service system.

- Have their rights protected and effective advocacy efforts promoted.

- Receive culturally competent/appropriate services, which are sensitive and responsive to cultural and gender differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, sexual orientation, or other characteristics.

The system-of-care concept also is built on the recognition that children and adolescents and their families have multiple needs that cross traditional agency boundaries and that coordination among child- and family-serving agencies is essential at both the system and client levels. The services that comprise the system of care include an array of nonresidential and residential services that go well beyond the outpatient, inpatient, and residential treatment center services traditionally provided by many communities. Since residential services have proven to be costly and of questionable effectiveness in integrating youth back into their families and communities, the system of care required by this program includes a range of community-based service options, including home-based services, therapeutic foster care, and individualized services. Thus, the system-of-care concept upon which this program is based calls for an organized service support system that emphasizes comprehensive and individualized, culturally competent/appropriate services provided in the least restrictive environment; the full involvement of families; interagency collaboration at the system level; and care coordination at the client level. This organized system of care should be the template for any managed care initiative(s) that may be occurring in a State or political subdivision.

Family Involvement

Family involvement refers to the identification, outreach efforts, and engagement of diverse families (an inclusive term to describe families of various races, ethnicities, gender orientations, socioeconomic backgrounds, and family structures) receiving services from the proposed system-of-care community and of the target population (as defined in the Target Population section in the RFA), so that their experiences and perspectives collectively drive the planning, implementation, and evaluation of the system of care.

Family-run Organization

A family-run organization is a private, nonprofit entity that meets the following criteria:

- Its explicit purpose is to serve families who have a child, youth, or adolescent with a serious emotional disorder (children, youth, and adolescents who have an emotional, behavioral, or mental disorder, age 0-18; or age 21, if served by an Individual Education Plan (IEP).
- It is governed by a board of directors comprised of a majority (at least 51 percent) of individuals who are family members.
- It gives preference to family members in hiring practices.
- It is incorporated as a private, nonprofit entity (i.e., 501C-3).

Family Member

A family member is an individual who is a **primary** caregiver for a child, youth, or adolescent with a serious emotional disturbance (an emotional, behavioral, or mental disorder). The primary caregiver may be provided with a significant level of support by extended family members. Families who have children, youth, and adolescents with a serious emotional disturbance are organized in a wide variety of configurations, regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, kinship caregivers, friends, and others as defined by the family.

Appendix B

Program Requirements for the Development of Systems of Care

The Comprehensive Community Mental Health Services Program for Children and their Families provides funds for infrastructure development and a service provision for children with a serious emotional disturbance and their families. This appendix describes the requirements and the approach for (1) infrastructure development, and (2) the service provision. In addition, it outlines requirements for implementing (3) key activities of the service provision, including the delivery of clinical interventions, delivery of care management services, and development of an individualized service plan. Furthermore, this appendix provides details about the critical (4) systems-of-care activities of family involvement, youth involvement, and cultural competence.

Systems-of-care development efforts are difficult to implement without the (5) support activities of evaluation, technical assistance, and social marketing. This appendix also describes the requirements for participation in these support activities. At the end of this section, awardees will find a (6) schedule that explains the requirements for developing the system of care in phases throughout the 6-year period. The systems-of-care development approach described in this appendix is guided by the principles of systems of care, as articulated in Stroul and Friedman (1994) and summarized in Appendix J, Core Values and Principles of Systems of Care.

1. Infrastructure Development

Infrastructure development refers to the administrative procedures and administrative structures that awardees must implement on a phased schedule throughout the 6-year Federal funding period to increase the capacity of a community-based system of care to provide a broad array of services for children with a serious emotional disturbance and their families.

Some key administrative procedures that awardees must develop include:

- ***Systems integration***, which is viewed as the organization and coordination of institutional resources available through Federal, State, and local human service systems responsible for serving children with a serious emotional disturbance and their families. Strategic planning, consolidation of funding streams, and policy formation are used as tools for these integration efforts. These efforts should result in the creation of a well-organized system-of-care entity, which is the main goal of the CMHS program, but, additionally, efforts may lead to the creation of an integrated public health and welfare service authority, managed care organization, commission of children and their families as consumers, youth and family support organization, and other such systemwide entities.

  As part of systems integration, the Comprehensive Community Mental Health Services Program for Children and their Families requires that the local system of care develop formal relationships with the State, tribal, or territorial mental health authority to increase the likelihood of sustaining the local community-based system of care, and also to provide an

effective systems-of-care model that can be replicated across the State. The State mental health authority must include implementation of the local system of care in statewide policy and fiscal initiatives to increase the likelihood of sustainability. Specifically, the implementation of the local system of care funded under the Federal cooperative agreement should, at a minimum, be included in the goals of the State's Community Mental Health Services Block Grant Plan and in the goals of the State Mental Health Plan for Children with Serious Emotional Disturbance, submitted under Public Law 102-321. The State mental health authority also should ensure that the local system of care is a Medicaid provider, as required in Section 561(a)(2)(b)(2) of the Public Health Service Act.

In addition, the applicant for this cooperative agreement program must provide a plan on how the State mental health authority intends to replicate the systems-of-care model across the State. The replication plan from the State mental health authority may include approaches at various levels of effort, including replication of the systems-of-care model:

- After the 6 years of Federal funding; and
- During the 6 years, through a phased and strategic approach across one or more counties within the State.

If a replication plan is developed during the 6 years of Federal funding, the applicant, in collaboration with the state mental health authority, must ensure that the plan will not, in any way, compromise the intent of the cooperative agreement program to develop systems and services of community-based systems of care in specific jurisdictions.

- ***Interagency collaboration***, which is defined as formal arrangements that child-serving agencies make among themselves to enable provision of the broad array of services. ***Child-serving agencies*** include those that deliver services in the areas of mental health, education, child welfare, child protection, juvenile courts, juvenile corrections, primary health care, and specialty services such as substance abuse treatment and prevention, vocational counseling, and rehabilitation. They must be located in the community or have the capacity and authority to provide services in the community. Formal arrangements must be stated clearly in memoranda of agreement, policy manuals, board minutes, or other documents shared among the agencies. These documents should specify the role that each agency plays in the system of care. At a minimum, they should specify each agency's financial or in-kind contribution, official representation in the governance structure, participation in strategic planning, and participation in service delivery tasks. They also should specify whether the agency is a local or State entity and indicate any special requirements that must be met for participation of the local or State agency. A staff person should be designated to implement the above arrangements.

- ***Service integration***, which refers to the efforts of a care manager, together with an individualized care team, to organize and coordinate multiple services and to arrange for their efficient and effective delivery to a child with a serious emotional disturbance and the child's family. An individualized service plan is a tool that the care manager and the individualized care team use for service integration. One goal of service integration is to

eliminate and avoid duplication of efforts, especially when services are delivered through collaborating child-serving agencies. More importantly, however, the goal is for the child and the child's family to have a unified, efficient, and supportive service experience.

- ***Wraparound process***, which is defined as activities that help to organize the delivery of a set of multiple services, treatments, and supports to a child and the child's family. This set of multiple services, treatments, and supports is aimed at meeting the unique needs of the child and the child's family. Some of the services may be delivered through formal agency procedures, but others may be delivered through informal arrangements in the community. One of the formal activities often associated with the wraparound process is the use of flexible funds. ***Flexible funds*** refer to service monies that can be used for many nonreimbursable service items to meet nontraditional needs. For example, flexible funds may be used to pay for horseback riding lessons for a child with a serious emotional disturbance who expresses a strong interest in this recreational activity. In this situation, horseback riding has the potential for having a positive therapeutic effect on the child. Like the individualized service plan, the wraparound process is another tool for service integration.

- ***Care review***, which is used by a designated interagency group to examine how well services are being delivered to individual children and their families. The purpose of such examination is to develop recommendations for improving the adequacy, appropriateness, and quality of the services and the procedures for delivery of those services. Special attention is given to how well each child-serving agency is contributing to meet the individual needs of children. The intent is not to review the individualized service plan of each child, but rather to select a set of individualized service plans that exemplifies the variety of needs found among the children and their families, as well as the most frequently encountered service delivery barriers and difficulties. The review group also examines other care records, and it arranges for interviews with the child, key family members, care managers, and other caregivers involved in service delivery.

- ***Access***, which refers to the ease with which eligible children and their families are able to receive services. Children and their families are provided with clear and comprehensible eligibility criteria. Procedures for determining eligibility and entry into services are efficient and timely. Services are located within distances that make it relatively easy for children and families to reach.

- ***Financing approach***, which refers to the capacity to obtain the necessary funding to maintain and enhance the system of care beyond the 6-year Federal funding period. Specifically, it refers to: (1) funding for services from collaborating State and community child-serving agencies; (2) access to existing categorical service funds from public and private sources for which children with a serious emotional disturbance and their families are eligible, such as Medicaid, the Child Health Insurance Program, and private insurance; and (3) other public and private funds to support systems-of-care activities and structures, other than services such as training, research, and equipment. The system of care also is fiscally accountable to each funding source.

- ***Workforce development***, which refers to the training strategies the system of care uses to increase the knowledge and skills of the workers who manage the system of care and deliver the services to children and families. Training strategies may include in-service educational opportunities such as seminars, workshops, institutes, and continuing education units. They also may include scholarships or time-off awards to participate in formal educational experiences such as certification programs and professional degree programs. Training partnerships with higher education institutions in the community are encouraged. A model for these partnerships was pioneered by the PEN-PAL program in North Carolina, which was one of the first 22 grantees funded by the Comprehensive Community Mental Health Services Program for Children and their Families in 1993 and 1994. The PEN-PAL program emphasized the involvement of family members in providing training for new professionals preparing to serve in systems of care.

- ***Support from community leaders***, which is defined as the endorsement given by community leaders (e.g., judges, mayors, clergy, business executives, presidents of educational institutions), including leaders from racial and ethnic minority populations, of the goals and activities of the system of care. Such endorsement may be given through public statements, financial contributions, or direct representation in the governing body of the system of care.

The awardee also must implement several administrative structures that are necessary for the development of the system of care. These include:

- ***Clinical network***, which is defined as the set of services, treatments, and supports that exist and are available within the system of care to serve children with a serious emotional disturbance and their families. Each awardee is urged to enhance and develop its clinical network to the highest possible level of quality. The network should aim to serve as a model of system reform in the State. To achieve this goal, awardees should avail themselves of training and technical assistance opportunities offered by the Comprehensive Community Mental Health Services Program for Children and their Families that have the potential to increase the quality of the clinical network. Awardees also should use findings from the program's National Evaluation to identify gaps and make adjustments in the clinical network and how it functions. In addition, awardees should implement to the greatest possible extent Federal or professional practice standards and guidelines for the delivery of children's mental health services. These standards and guidelines may focus on the delivery of specific clinical interventions, but they also may address the delivery of systems-of-care services such as intensive care management, therapeutic foster care, and home-based crisis intervention. Awardees are strongly encouraged to include in their clinical network one or more evidence-based service or treatment that has been shown to be effective in research studies.

- ***Governance body***, which refers to a group of individuals with the authority to make policy decisions for the system of care. The group includes representatives of the public entity which was awarded the Federal funds and also representatives of collaborating state or community child-serving agencies, family members, and other community representatives, including representatives from racial or ethnic minority populations. This governing body

may be organized as a board of directors of a newly incorporated system of care or as a committee, task force, workgroup or other such decision-making body of an existing human service agency. This body develops and upholds formal agreements and memoranda of understanding between the collaborating child-serving agencies, including those from the State and from other relevant political subdivisions of the State. It also holds the system of care accountable for meeting high standards of care, including standards for cultural competence and family involvement, as well as standards of practice that have been shown to be effective through research and evaluation studies. The governance body must see that cooperative agreement funds are expended appropriately within the community. The body should be aware of relevant reform efforts in the State and incorporate each into the system of care, as required, or as appropriate. It must regularly monitor the clinical and functional outcomes of children to ensure that services are making a positive contribution to the well-being of the children and their families.

- ***Administrative team***, which represents the group of individuals responsible for managing, implementing, and developing the system of care. Specifically, this team will:

  - Develop a strategic plan;
  - Coordinate services delivered through the collaborating child-serving agencies;
  - Budget, manage, and expend service funds for required services;
  - Integrate funding streams, as appropriate;
  - Award and manage contracts for service delivery, training, technical assistance, evaluation, and social marketing, as appropriate;
  - Use findings from the National Evaluation and any local evaluation to shape future program direction, decisions about practices and policies that work, and the development of a managed care approach, as appropriate;
  - Implement care review procedures;
  - Monitor the extent and quality of implementation of individualized service plans;
  - Examine the extent to which living and service placements for children are made in the least restrictive, most normative, and safest environments that also are clinically appropriate;
  - Monitor the degree to which care management and other services enhance the strengths, resilience, protective factors, and well-being of the child and the child's family;
  - Comply with the rules and regulations for electronic exchange of information and for confidentiality of care records, as required by the Health Insurance Portability and Accountability Act (HIPAA).

- ***Training capacity***, which is defined as the existing resources and practices for increasing the knowledge and skills of the workers who manage the system of care, develop its infrastructure, and deliver services to children and families. These resources may include specific dollars budgeted to hire trainers and consultants with specific expertise in areas such as system leadership, fiscal management, personnel management, implementation of clinical interventions and the wraparound process, quality improvement, and evaluation.

- ***Performance standards***, which are defined as the criteria or benchmarks that have been

established to measure the degree to which the system of care has met quality and effectiveness goals. These goals may be in areas such as access, capacity, clinical outcomes, service provision, infrastructure development, workforce training, and others.

- ***Management information system*** (MIS), which refers to a computerized system for the electronic storage, management, and exchange of information within the system of care. At a minimum, this system should be used to record the type, amount, and cost of services delivered to each child in the system of care. These services should include those reimbursed by Medicaid and also those covered by cooperative agreement funds and by any other State or private funding streams. There should be a close correspondence between the services delivered as part of the individualized care plan and the services recorded in the MIS. As much as possible, the MIS should be integrated across the collaborating child-serving agencies and be used as a tool for the coordination of service delivery. In addition, the MIS should have the capacity to integrate child and family outcome data from the National Evaluation. The MIS procedures should be compliant with HIPAA specifications.

- ***Office in the community***, which is defined as a facility located within the geographic bounds of the system of care, from which service delivery is managed and coordinated.

2. Service Provision

Certain mental health and support services are required and must be provided by awardees. Other services, including training and continuing education, are optional. Some nonmental health services need to be included in the individualized service plan, even though funds from the cooperative agreement cannot be used to purchase them.

Required Mental Health and Support Services. The system of care developed by the local public entity must establish a full array of mental health and support services in order to meet the clinical and functional needs of the target population. This array must consist of, but is not limited to, the following:

- Diagnostic and evaluation services;

- Care management;

- Development of an individualized service plan;

- Outpatient services provided in a clinic, office, school, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and management of medication;

- Emergency services, available 24 hours a day, 7 days a week, including crisis outreach and crisis intervention;

- Intensive home-based services for children and their families when the child is at imminent

risk of out-of-home placement, or upon return from out-of-home placement;

- Intensive day treatment services;
- Respite care;
- Therapeutic foster care;
- Therapeutic group home services caring for not more than 10 children (i.e., services in therapeutic foster family homes or individual therapeutic residential homes); and
- Assistance in making the transition from the services received as a child to the services received as an adult.

The required services listed above should be integrated, when appropriate, with established alternative healing practices of racial or ethnic minority groups represented in the community, especially if there are indications that such integration will reduce racial or ethnic disparities in mental health care.

Section 562(g) of the Public Health Service Act allows for a waiver of one or more of the above service requirements for applicants who are an Indian Tribe or tribal organization or American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, or the United States Virgin Islands, if CMHS staff determine, after peer review, that the system of care is family-focused, culturally competent, and uses the least restrictive environment that is clinically appropriate.

Optional Services. In addition to the mental health services described above, the system of care may provide the following optional services:

- Screening assessments to determine whether a child is eligible for systems-of-care services;
- Training in the following areas:
    - Implementation of individualized service plans and management of individualized care teams;
    - Provision of intensive care management, intensive home-based services, intensive day treatment, therapeutic foster care or therapeutic group homes caring for not more than 10 children, clinical practices, emergency services, crisis outreach, crisis intervention, and respite care;
    - Administration of the system in areas such as managed care, strategic planning, interagency coordination, fiscal management, management information systems, personnel management, and project management, as long as such training is directed toward reinforcing systems-of-care practices and not the practices of a conventional

service system;

- Implementation of evidence-based clinical interventions, which are defined as interventions that have been scientifically shown to be effective; and

- Development and implementation of practices and interventions that are appropriate for specific racial or ethnic groups and have the potential to eliminate disparities in mental health care.

- Recreational activities; and

- Other mental health services that are determined by the individualized care team to be necessary and appropriate and to meet a critical need of the child or the child's family related to the child's serious emotional disturbance.

NOTE: Cooperative agreement funds and matching funds can be used to purchase individualized optional services from appropriate agencies and providers that directly address the mental health needs of children and adolescents in the target population. However, the funding of these services should not take precedence over the funding of the array of required services in this RFA.

Nonmental Health Services. Funds from this program cannot be used to finance nonmental health services. Nonetheless, nonmental health services play an integral part in the individualized service plan of each child. The system of care must facilitate the provision of such services through coordination, memoranda of understanding, and agreement with relevant agencies and providers. These services should be supplied by the participating agencies in the system of care and include, but are not limited to:

- Educational services, especially for children who need to be placed in special education programs;
- Health services, especially for children with co-occurring chronic illnesses;
- Substance abuse treatment and prevention services, especially for children with co-occurring substance abuse problems;
- Vocational counseling and rehabilitation, and transition services offered under IDEA, for those children 14 years or older who require them; and
- Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families in the foster care system, who need to know about their rights as consumers of services, and assistance for any child with a serious emotional disturbance and the child's family about appropriate services available to them.

A relatively high percentage of adolescents with a serious emotional disturbance are expected to have a co-occurring substance use disorder. In such cases, treatment for the substance use disorder should be included in the individualized service plan. For those children with a serious emotional disturbance who are at risk for, but have not yet developed, a co-occurring substance use disorder, prevention activities for substance abuse may be included in the individualized

service plan.

Children with a serious emotional disturbance often have co-occurring chronic illnesses. Therefore, collaboration with the primary care system, including collaboration with family physicians, pediatricians, and public health nurses, must be developed within the system of care. Such collaboration must include, at a minimum, systematic procedures that primary care providers can follow to refer children and their families to the system of care. It also must include procedures for including primary care providers in individualized service planning teams and in the wraparound process.

In addition, the local entity must develop memoranda of understanding with appropriate agencies and providers for delivery of services available under Federal entitlements, including:

- Title XIX,
- Title IV-A,
- Title IV-B and Title IV-E of the Social Security Act,
- Early Periodic Screening, Diagnostic and Treatment Program (EPSDT), and
- Individuals with Disabilities Education Act, both Parts B and H, specifically linking an individualized service plan developed under this program with an Individualized Education Plan or efforts developed in compliance with the Family Preservation and Support Act.

The memoranda of understanding also must include specification of any collaboration with other Federal discretionary grant programs available in the community such as:

- Safe Schools/Healthy Students, funded by CMHS-SAMHSA,
- Building Healthy Communities, funded by CSAP-SAMHSA, and
- Strengthening Communities - Youth, funded by CSAT-SAMHSA.

These memoranda of understanding are to be included in Appendix No. 1 entitled, Memoranda of Understanding for Services Coordination and Evaluation.

3. Key Activities of Service Provision

The provision of systems-of-care services for children with a serious emotional disturbance and their families emphasizes: (1) delivery of effective clinical interventions, which as research has demonstrated, produce positive child outcomes; (2) provision of care management services for each child and the child's family; and (3) development of an individualized service plan for each child and the child's family.

Delivery of Clinical Interventions. The system of care must ensure that children with a serious emotional disturbance have access to the most effective clinical interventions. A ***clinical intervention*** refers to a service, treatment, or therapy that is used to treat a specific diagnosable emotional, behavioral, or mental disorder, or a combination of co-occurring disorders, and is delivered by trained personnel. The system of care should, at a minimum:

- Implement one or more ***evidence-based intervention***, which is defined as one that has been scientifically studied and has been found to produce positive outcomes in children. Typically, an evidence-based intervention includes:

  - A written manual that serves as a procedural guide for implementing and replicating the intervention. The purpose of the manual is to ensure adherence to a specific set of intervention procedures referred to as the ***intervention protocol.*** The purpose also is to promote the delivery of an ***effective intervention*** that results in positive individual outcomes that are better than the outcomes from conventional, untested interventions, or better than the absence of any intervention. A written manual also is expected to result in a ***quality intervention***, which is defined as one that is delivered efficiently to a child and the child's family and produces high satisfaction and acceptability by the child and the child's family receiving the services.
  - Several research studies that, as a set, produce reliable, valid, and generalizable findings about the effectiveness of the intervention. These findings demonstrate that the intervention results in consistent positive outcomes across children. They also indicate that positive outcomes are found among a specific population for whom the intervention was intended (e.g., children experiencing major depression). Findings also show that the outcomes of the intervention can be replicated consistently among different population groups (e.g., racial or ethnic) and in different settings (e.g., rural, urban).
  - Specification of a clinical population for which the treatment applies such as children with depression, attention deficit/hyperactivity disorder, or oppositional defiant disorder.

  The system of care offers the best possible programmatic, fiscal, and organizational context for implementing and sustaining evidenced-based interventions, because it:

  - Offers a strategic public health approach for using the evidence-based intervention to meet a specific clinical need of the entire population of children with a serious emotional disturbance and their families living in a specific jurisdiction;
  - Provides a method for fiscally sustaining the evidence-based intervention through the financial contributions of the various child-serving sectors that collaborate to meet the specific and multiple needs of these children; and
  - Creates the organizational structures and processes to integrate the evidence-based intervention into the individualized service plan for a child with a serious emotional disturbance and the child's family.

  Communities interested in implementing evidence-based interventions and best practices are encouraged to seek out sources of information such as the National Registry of Effective Practices (NREP) (See the www.samhsa.gov web site.), the *Blueprint for Change: Research on Child and Adolescent Mental Health* (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; see http://www.nimh.nih.gov/child/blueprint.cfm.), and the *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and

Human Services, 1999).

- Ensure that procedures for diagnostic and treatment planning will match the specific mental health needs of the child with the most appropriate treatment or combination of treatments;

- Encourage implementation of state-of-the-art, community-based treatments;

- Make necessary adaptations to innovative evidenced-based interventions for the target populations, particularly for racial and ethnic minority populations in the specific communities involved;

- Conduct clinical assessments in a manner that recognizes gender and cultural differences in the diagnosis of overt behaviors and the evaluation of presenting problems; and

- Address the training needs of clinicians in several areas, including the delivery of evidenced-based treatments and appropriate application of DSM-IV diagnostic categories.

Delivery of Care Management Services. Care management, or care coordination services, tailored to the needs of individual children are required for all children and adolescents who are offered access to the system of care under this program. ***Care management*** represents the procedures that a trained service provider uses to access and coordinate services for a child with a serious emotional disturbance and the child's family.

The system of care will provide each child in the target population with an appropriate level of care management. Care management services should, at a minimum:

- Unify services provided to the child and the child's family, including those specified in the individualized service plan and any other service.

- Establish eligibility of the child and the child's family for any financial assistance and services under Federal, State, and local programs, and document that such services and supports are received;

- Reassess the needs of the child and the child's family at regularly established intervals, and modify the individualized service plan accordingly;

- Provide the family with information on the extent of progress made toward the objectives in the individualized service plan;

- Create intensive or therapeutic care management services for children with the most severe emotional disturbances at a ratio of no more than 10 children for every one intensive care manager; and

- Create care management services for children with a serious emotional disturbance whose

needs are less complex than those with severe needs, but who still require regular monitoring of service delivery. The ratio of assigned children for this type of care manager should be no more than 15 to one.

Development of an Individualized Service Plan. Each child or adolescent served within the system of care funded under this program must have an individualized service plan developed by an interagency team, which includes the child's parents and, unless clinically inappropriate, the child. The ***individualized service plan*** refers to the procedures and activities that are appropriately scheduled and used to deliver services, treatments, and supports to a child and the child's family. These procedures and activities must fit the unique needs of the child and the child's family. The group that assists the care manager, family member, and child to implement the individualized service plan is the ***individualized care team***. This team is comprised of representatives from child-serving agencies that provide services to the child and the family, as well as other significant individuals in the community who relate closely to the child and family, such as a minister, friend, or community leader.

Development of the individualized service plan must include:

- An emphasis on building upon the existing strengths of the child and the child's family.

- Coordination with services available under parts B and H of the Individuals with Disabilities Education Act (IDEA), including consistency and coordination with the Individualized Education Plan (IEP).

- Coordination with services available through the U.S. Department of Health and Human Services, Administration for Children and Families' Family Preservation and Support Program (Title IV-B, Subpart 2, Social Security Act).

- Inclusion and implementation of the following components of the plan:

  a. Description of the need for services;

  b. Recognition of existing strengths of the child and the child's family;

  c. Development of objectives that meet the needs of the child and the child's family and which build upon the existing strengths of the child and the child's family;

  d. Development of a methodology for meeting these objectives;

  e. Provision of nonmental health services, as appropriate, and as outlined in Section 2 of this Appendix; and

  f. Designation of the lead agency responsible for care management services.

- Review of the appropriateness of services in the individualized service plan, and revisions

when necessary, or at least quarterly.

4. Activities of Family Involvement, Youth Involvement, Cultural Competence, and Early Intervention

Family involvement, youth involvement, cultural competence, and early intervention represent other key activities that must be implemented in a system of care. ***Family involvement*** refers to the active participation of family members in decisions about the care of their child with a serious emotional disturbance and also in decisions about systems-of-care development and service provision for other children and their families. ***Youth involvement*** is viewed as the active participation of youth in decisions about the care they receive, as well as decisions about systems-of-care development and service provision to other youth. ***Cultural competence*** is defined as the attitudes, knowledge, and skills of individual service providers when working with children with a serious emotional disturbance and their families who are from racial or ethnic minority groups in the community. These attitudes, knowledge, and skills must contribute to the well-being of the target children and their families. Cultural competence also refers to the policies and practices of the system of care that have a positive effect on the well-being of these children and their families. Finally, in this RFA, ***early intervention*** represents service and service system activities for meeting the needs of infants and preschoolers, from birth to age 7, who have an identified serious emotional disturbance.

Racial or ethnic minority groups, in this RFA, refer to the four racial or ethnic groups that have been found to be nationally underserved in the area of health care, including the African American, Hispanic, American Indian and Alaska Native, and Asian American and Pacific Islander groups. These groups also include underserved immigrant and refugee groups who have recently arrived in the United States from other countries of the world.

Family Involvement. The system of care must develop and incorporate practices of family involvement that include:

- Family member participation in planning, implementing, and evaluating the project;
- Creation of a local parent support organization or serving to complement an established initiative (such as a CMHS-funded Statewide Family Network grantee), where there is no existing family-run organization in the target community;
- Designation of a full-time equivalent position for a family member to serve as the key family contact for the system of care. At a minimum, the responsibilities of the ***key family contact*** should include advocacy for other family members of children receiving services; outreach to family members of children not receiving services; and serving as one of the family member representatives on the governance body;
- Financial support to sustain family involvement in the system of care beyond the Federal funding period;

- Creation of a strong partnership between professionals and family members that enables family members to participate in the planning, management, and evaluation of the system of care; and

- Compensation and fiscal support for families whose children are eligible for services, as well as the existing family organizations whose focus is on these children and families. The aim of such support is to enable family members and family organizations to participate in activities related to the development, implementation, and evaluation of the system of care. The support also should be provided for families and family organizations from racial or ethnic minority backgrounds in the community.

Youth Involvement. Activities to support youth involvement should include:

- Designation of an individual to serve as youth coordinator in the system of care. Duties of the ***youth coordinator*** should, at a minimum, include helping to form an organized group among youth receiving services; advocating for youth who are receiving services; reaching out to eligible youth who are not receiving services; and representing youth on the governance body.

Cultural Competence. The following activities are designed to enhance the cultural competence of the system of care:

- Complying with Title VI of the Civil Rights Act.

- Reaching cultural competence standards, as suggested in documents such as the Culturally and Linguistically Appropriate Standards (CLAS) in Health Care, published by the U.S. Department of Health and Human Services, and those included in CMHS' **Cultural Competence Standards** publication.

- Recommending the incorporation of culturally appropriate practices in the individualized service plan, such as using the preferred language of the child and the child's family during service delivery; nurturing the strengths and customs of the child and the child's family that are part of their cultural or religious heritage; and recognizing behaviors and beliefs of the child and the child's family that are normal in their culture.

- Inviting individuals from racial or ethnic minority groups in the community to participate in activities of such systems-of-care entities as the governing body, administrative team, care review group, and individualized care team. These individuals should be able to serve as advocates for children and families from these cultural groups.

- Providing evidence that the management plan, staffing pattern, project organization, and resources are appropriate and adequate for carrying out all aspects of the proposed project and are sensitive to issues of language, age, gender, sexual orientation, race, ethnicity, and culture.

- Expanding the services available through the system of care to include service providers representing the racial and ethnic composition of the community.

- Addressing disparities in access to care, quality of mental health services, availability of effective clinical interventions, satisfaction with services, and other systems-of-care outcomes for children and their families from racial or ethnic minority groups.

- Planning for service provision (1) in the cultural context preferred by the child and the child's family; and (2) without discrimination against the child or the child's family on the basis of race, religion, national origin, sex, sexual orientation, disability, or age (i.e., for the child, age 21 years or younger).

Please also refer to the SAMHSA documents, Elements of Cultural Competence in Appendix D, and Limited English Proficiency Assistance in Appendix E.

Early Intervention. A system of care that addresses the needs of infants and preschoolers with a serious emotional disturbance must include, at a minimum:

- Appropriate assessments for the identification of infants and preschoolers with a serious emotional disturbance.
- Collaborative arrangements with the primary care sector (e.g., family physicians, pediatricians, public health nurses). These arrangements may include a system of referrals to systems-of-care services for the child and the family and also guidelines for treatment of these children, especially when a serious emotional disturbance may co-occur with a chronic illness.
- Integration of services provided through the child care provider system, the early education system, and the infant and early childhood public health system. Such integration should occur across Federal and State programs, including Head Start, Early Head Start, and Healthy Families.

5. Activities That Support Systems-of-Care Development

The Comprehensive Community Mental Health Services Program for Children and Their Families provides evaluation, technical assistance, and social marketing support to awardees to assist them with their efforts to develop systems of care.

Evaluation. Section 565(c) of the Public Health Service Act requires that evaluations be conducted to assess the effectiveness of systems of care. Specifically, these evaluations must include:

- Longitudinal studies of outcomes of services provided through systems of care;

- Other studies regarding service outcomes;

- Studies on the effect of systems of care on the utilization of hospital and other institutional settings;

- Studies on the barriers and achievements that result from interagency collaboration; and

- Studies on parental perceptions of the effectiveness of systems of care.

The Comprehensive Community Mental Health Services Program for Children and Their Families will award a contract to a private entity to develop a cross-site program evaluation that will be used to comply with the requirements described above. This cross-site evaluation is referred to in this RFA as ***the National Evaluation***. It applies multiple methods for conducting the evaluation, and it is designed to maximize the usefulness of the results for developing systems of care among awardees. It also is designed to create long-term capacity among the awardee communities to evaluate themselves, especially after Federal funding ceases. Awardees are required to participate in the implementation of the National Evaluation.

During the first year of the cooperative agreement, each awardee will receive detailed instructions about the design of the evaluation and the procedures for implementing each component of the evaluation. For example, one component requires implementation of a longitudinal outcome study that includes the enrollment and follow-up of approximately 100 children per service year, with a total representative sample of about 300 to 400 children over the 6-year Federal funding period. At the time of enrollment, a baseline assessment of the child and the child's family will be administered. Follow-up assessments will occur at periodic intervals (e.g., every 6 months for up to 3 years) while children are receiving services, and after these services have terminated.

The National Evaluation includes measures for the characteristics and outcomes of children, their families, the system of care, and the services delivered through the system of care. Measures for the characteristics of children and families include, but are not limited to:

- The total number of children served in the system of care;

- Child and family characteristics for each racial, ethnic, age, and gender group represented in the community, including, but not limited to:

  - Demographic characteristics of children and families (e.g., age, sex, race and ethnicity, family composition, family income, family member employment status, family member educational status);
  - Diagnostic characteristics, including primary, secondary, tertiary, as well as primary presenting problem(s);
  - Child and family risk and protective factors;
  - Child and family mental health service history;
  - Description of the enrollment features at each site, such as the number of children admitted, active, and discharged each month; number of children and their families who consented to participate in the evaluation each month; and number of children who were selected to participate in the follow-up sample.

- Child and family outcomes for each racial, ethnic, age, and gender group represented in the community, including, but not limited to:

- Behavior, as assessed through such standardized instruments as the Child Behavioral Checklist (CBCL) and the Youth Self Report (YSR);
- Functional impairment, as measured through such instruments as the Child and Adolescent Functional Assessment Scale (CAFAS);
- Functional status, as assessed through indicators such as school attendance, school grades, school achievement, juvenile justice status, contacts with law enforcement, independent living, youth employment, higher education, and family functioning;
- Youth and family satisfaction;
- Working relationship or alliance between family members and professionals;
- Restrictiveness of service placement;
- Stability of living arrangement;
- Change in child and family physical health and substance abuse;
- Change in welfare status of children and families, such as time limits on Temporary Assistance for Needy Families (TANF);
- Assessment of eligibility and participation in the Federally funded Child Health Insurance Program (CHIP);
- Immigration and migration status and characteristics; and
- Level of acculturation of the child and the child's family.

System characteristics, including, but not limited to:

- Estimates of unmet need;
- Rates of service penetration into unmet needs among each racial, ethnic, and cultural group represented in the community;
- Access to services;
- Types and unit amounts of services provided through the individualized service plan, including services for special populations such as each racial, ethnic, age, and gender group represented in the community;
- Funding sources and fiscal information obtained from charges, actual expenditures, and budget figures obtained from the management information systems of each collaborating child-serving agency;
- System costs for specific services obtained from management information systems, in collaboration with child-serving sectors, such as mental health, juvenile justice, child welfare, and education;
- Standard data reported in management information systems, such as suicide;
- Availability and use of private insurance and other third party reimbursements, such as Medicaid;
- Collaboration and coordination among system components (e.g., child-serving agencies, family organizations, services);
- Adequacy and effectiveness of interagency governance structures;
- Adequacy of participation of youth and family members in service development and service planning, including family members in each racial, ethnic and cultural group represented in the community;
- Establishment of a jurisdiction-wide system of care;
- Development of the system of care into a managed care model;
- Accessibility and confidentiality of care records;

- Capacity of the system of care and its collaborating child-serving agencies to serve children with a serious emotional disturbance and their families;
- Cultural competency of the system of care, including the cultural competency of provider organizations and individual providers and the degree to which the system of care collaborates with organizations (e.g., faith communities) and individuals (e.g., folk healers), which represent the cultural groups in a community and provide mental health supports to children and families;
- Availability of mental health providers who are from the racial and ethnic communities represented in the system of care;
- Availability of culturally competent specialty providers in areas such as clinical interventions and substance abuse services;
- Compliance with limited English proficiency (LEP) standards and requirements;
- Integration of individuals from diverse communities into the governance structure;
- Use of telecommunications technology for rapid transmission of data, reports, and studies between the sites and the Contractor;
- Systems-of-care development;
- Potential to sustain the system of care beyond the 6-year Federal funding period; and
- Capacity of the project to (1) establish a jurisdiction-wide system of care, (2) develop the system of care into a managed care initiative, and (3) provide children and their families with access to care records.

Regular training and technical assistance sessions will be conducted on-site, during awardee meetings, and at other scheduled times throughout the 6-year Federal funding period. Evaluation staff and other systems-of-care staff will be asked to participate in these training and technical assistance sessions.

To meet requirements of the National Evaluation, awardees will be required to:

- Adhere closely to the design of the National Evaluation.

- Implement procedures for collection, entry, management, and storage of data.

- Transmit data to the National Evaluation contractor on a regular basis.

- Report evaluation findings on the local system of care to the stakeholders of the system of care, including family members, personnel of collaborating child-serving agencies, clinical staff, members of the governing body, and others.

- Use evaluation findings to inform system-of-care development efforts, including improvement of management procedures, adoption of new system and service policies, attainment of new sources of public and private financing, and others.

- Involve youth who are receiving services and their family members in the implementation of the National Evaluation.

- Obtain written assurances from each participating agency indicating a willingness to cooperate with the required activities of the National Evaluation. Assurances are to be

included in Appendix No.1.

- Hire at least two full-time equivalent (FTE) evaluation staff. One FTE must have an earned Ph.D. in public health, psychology, social work, or other relevant area of human services. At least one of the full-time evaluation staff should have an office located in the awardee community. Evaluation staff must have knowledge of and experience with coordinating and implementing longitudinal data collection activities, including tracking individuals, data management, data analysis, basic quantitative and qualitative evaluation methods, and report writing.

- Participate in an annual 2- to 3-day site visit conducted by the National Evaluation contractor to assess development of the awardees system(s) of care. Applicants must secure an agreement from each collaborating child-serving agency that staff will be available for the visit. (Relevant agreements should be provided in Appendix No. 1.)

- Obtain approval from an Institutional Review Board (IRB) associated with the system of care to perform the data collection requirements of the National Evaluation.

CMHS will obtain OMB clearance to conduct data collection for the National Evaluation, in compliance with the Paperwork Reduction Act of 1995. Such clearance will be obtained during the first year of the Federal funding period. Awardees will not implement the National Evaluation until OMB has approved the National Evaluation plans.

Each awardee will receive regular evaluation reports from the national evaluator that describe how the system of care is developing in its own community. Staff in the awardee communities should use this information to improve their systems of care, improve the clinical and functional outcomes of children with a serious emotional disturbance, and increase the participation of family caregivers in meeting the needs of their own children and in carrying out the systems-of-care development activities.

Each awardee is encouraged to also enhance the National Evaluation with its own local evaluation activities. These local evaluation activities will help ensure that the unique needs for systems-of-care development of the awardee's site are being met. Data and findings from local evaluation efforts do not need to be transmitted to the National Evaluation contractor, unless arrangements are made for a special study that can be valuable for the development of systems of care across the Nation. However, critical findings from local evaluation efforts may be reported in cooperative agreement re-applications and quarterly reports.

The National Institute of Mental Health (NIMH) has established a program announcement (i.e., PA 00-135: see http://grants1.nih.gov/grants/guide/pa-files/PA-00-135.html) to promote research on the implementation, practice, and effectiveness of communities awarded a cooperative agreement from the Comprehensive Community Mental Health Services Program for Children and Their Families. The systems-of-care communities funded by SAMHSA/CMHS

are encouraged to partner with an experienced researcher and to jointly submit, with the researcher, applications for grants funded through the NIMH program announcement. These research grants can be used to implement scientific studies to test the effectiveness of an entire system of care, or to test the effectiveness of specific interventions and practices offered within a system of care. It is hoped that systems-of-care communities will apply for the research funds from this program announcement to further illustrate how science can be used to increase the effectiveness of service systems and specific services.

Technical Assistance. The program provides awardees with training and technical assistance to assist them with the planning, development, and operations of the system of care.

Awardees will be required to:

- Develop a technical assistance plan for the system of care.
- Assess continuously the technical assistance needs of the system of care.
- Organize and implement training activities to address developmental needs of the system of care.
- Establish an interagency team to assist with the assessment, planning, and implementation of training and technical assistance activities. The interagency team also will assist with the identification of resources to address the training and technical assistance needs of each stakeholder group associated with the system of care.
- Designate at least a half-time equivalent staff person to serve as technical assistance coordinator.

Social Marketing. Awardees also will receive support from a communications contractor of the program to implement social marketing and communications activities.

Awardees will be required to:

- Develop a culturally and linguistically competent social marketing plan that includes: (1) providing information to the public regarding the system of care and its services; (2) educating the public about the needs of children with serious emotional disturbances and their families; and (3) recommending good mental health practices for meeting those needs.
- Designate at least a half-time equivalent position for a social marketing-communications manager.
- Provide support to a family organization associated with the system of care to implement outreach strategies with families of children with a serious emotional disturbance who are

from racial and ethnic minority groups represented in the community.

- Implement a social marketing strategy that determines the informational needs of target audiences and develops messages, materials, and activities that are in compliance with Title VI of the Civil Rights Act*, National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care* (U.S. Department of Health and Human Services, 2000; see http://www.omhrc.gov/clas/frclas2h.tm.), and the standards identified in SAMHSA's *Cultural Competence Standards in Managed Mental Health Care Services* (U.S. Department of Health and Human Services, 2000; see http://www.wiche.edu/mentalhealth/CCStandards/ccstoc.htm.)

6. System Development Schedule

Below is a description of the activities that should be scheduled during each phase in the development of the system of care. Please see Table 1 for a summary of these activities.

First-year Activities. The first year of the cooperative agreement will be used to:

- Develop a logic model of the system of care, which will serve as the basis for developing the strategic plan for the project. The logic model should, at a minimum, describe the context in which the system of care will be developed, the resources available for the system of care, the activities that will drive systems-of-care development, and the individual, service, and system outcomes expected from the system of care.

- Develop a strategic plan for implementation of the system of care throughout the 6-year Federal funding period. The strategic plan should specify how each of the activities described in this Appendix on Program Requirements for the Development of Systems of Care will be developed. In addition, the strategic plan should include a technical assistance plan that shows how training and technical assistance activities will be targeted to areas that require further development within the system of care.

- Hire key personnel.

- Establish the administrative team.

- Organize the governing body.

- Enhance and develop required services through: (1) the direct creation of new programs, (2) contracts with existing private, nonprofit service organizations, (3) coordination and expansion of services delivered by collaborating child-serving agencies, (4) and other such mechanisms.

- Develop an approach for service integration and coordination that is appropriate for the

target population;

- Create a format for the individualized service plan that incorporates a full array of mental health and support services.

- Identify resources and activities to address family involvement, youth involvement, and cultural competence in the system of care.

- Create the capacity to implement the National Evaluation.

Full Implementation – Two through Six. It is anticipated that the system of care will begin to operate during Year Two of the cooperative agreement. In other words, the system of care should begin to enroll and serve children and their families through its array of services and begin to enroll children and their families in the National Evaluation.

In Years Three to Six, the system of care will continue to enhance and maintain its capacity to meet the needs of target children and their families. It also will develop plans for sustaining the system of care beyond the 6-year Federal funding period.

Please see Table A-1 below for a summary of tasks that should be completed during each year of the cooperative agreement.

Table A-1. Summary of Main Tasks for the 6-Year Cooperative Agreement

Funding Year	Main Tasks

One	• Develop a logic model for the system of care, which will serve as guide for the strategic plan. • Develop a 6-year strategic plan, which expands on the implementation plan described in the application. • Develop a 6-year plan for technical assistance and training activities. • Hire key personnel. • Establish the administrative team. • Organize the governance body. • Enhance or develop required services. • Develop the approach for services integration and coordination. • Create the format for the individualized service plan. • Implement activities for family involvement, youth involvement, and cultural competence. • Build the capacity to implement the National Evaluation.
Two	• Begin to operate the system of care. • Begin to enroll and serve children and their families. • Enroll children and their families into the evaluation.
Three to Six	• Enhance and, ultimately maintain, the capacity to serve children and their families. • Develop a strategic plan to sustain the system of care beyond the 6-year period of Federal assistance that expands on the plan included in the application.

Appendix C

Background for Systems of Care

Public Law 94-142, The Individuals with Disabilities Education Act (IDEA), was passed to ensure that all children with disabilities have available to them a free and appropriate public education. Passed at a time when 1 million children with disabilities were excluded from the public school system, the Act mandated procedures to ensure that, to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are disabled. The Act has helped many children with disabilities to succeed in local schools and communities. However, children with a serious emotional disturbance, identified as the most difficult population of children to serve within the school setting and had no appropriate service system within the school setting and no appropriate service system within their home and community environment to offer support. As one Director of Special Education lamented, children with a serious emotional disturbance are the least understood and most difficult to serve, and so little money exists to serve them well. ***Unclaimed Children***, commissioned by the Children's Defense Fund and authored by Jane Knitzer, Ph.D., in 1982, further documented the plight of children with a serious emotional disturbance and their families.

Since 1984, the Federal government has supported the development of more accessible and appropriate service delivery systems for children and adolescents with a serious emotional disturbance and their families. One such effort was the Child, Adolescent Service System Program (CASSP). This demonstration program offered grants to States to design a system of care for children and adolescents who are experiencing a serious emotional disturbance and their families. The key principles behind designing these systems were: 1) involvement of the mental health authority for the State, county, and/or city; 2) collaboration of child-serving agencies on behalf of children and adolescents with a serious emotional disturbance and their families; 3) involvement of families as partners in planning, implementation, and maintenance; 4) systems of care that are culturally relevant and competent; 5) individualized services for each child and family; 6) child and family assessments that are strength-based; and 7) delivery of a broad array of services in the home and community.

Appendix D

Cultural Competence Elements

This appendix describes many of the important elements of cultural and linguistic competency. Applicants may refer to it, in addition to the standards and guidelines referred to in this RFA.

Project Description and Need Justification - Knowing the unique characteristics of the community/target population is critical to the success of the proposed project.

Experience or Track Record of Involvement with the Target Population – The applicant organization should have a documented history of programmatic involvement with the target population/community to be served by the proposed project. If your organization does not yet have a track record with this target population, your organization should plan to acquire the tools and information needed to become culturally competent (for instance, by establishing collaborations, designing and implementing a cohesive plan, seeking technical assistance, contracting services, sharing staff or location, or seeking special training and staff development).

Community Representation – The population/community targeted to receive services should participate actively in all phases of program design. A mechanism should be established to provide opportunities for community members (including consumers, providers of services, and representatives of informal systems of care) to influence and help shape the project's proposed activities and interventions. Such mechanisms may include, but are not limited to, establishment of an advisory council, cultural competence committee, and/or board of directors, with written working agreements that ensure their active participation and advisory assistance concerning the course and direction of the proposed project.

Language and Communication – Project-related communications must be appropriate to the target population/community. Consider information that is available about the target group's primary language(s) and literacy levels (for instance, whether a significant percentage of the target population/community is known to be more comfortable with a language other than English). Multilinguistic resources, which might include the use of skilled bilingual and bicultural individuals when appropriate, can be beneficial. Materials produced in English need to be adapted – not just translated – to meet the needs of non-English speakers. Audio-visual materials, public service announcements (PSAs), training guides, and print materials can be used, as well as materials produced as a result of the project, which are appropriate for the target population/community in terms of gender, age, culture, language, and literacy level.

Staff Qualifications and Training – The staff of the organization should have training in addressing characteristics of the target population (including race/ethnicity, gender, age, sexual orientation, disability, and literacy). For purposes of this item, "staff" would include, at a

minimum, administrators, advisors, board members, and service providers.

Evaluation - There should be a rationale for the use of the evaluation instrument(s) that are chosen, and the rationale should include a discussion of the validity of the instrument (s) in terms of the gender/age/culture of the group(s) targeted. The evaluators should be sensitized to the culture and familiar with the gender/age/culture, whenever possible and practical. Program evaluation methods and instruments should be culturally appropriate to the population/community served.

Efforts should be made to ensure findings are interpreted in a culturally competent and sensitive manner. Describe cultural issues you anticipate may influence outcomes for your target population (including, potentially, the impact of using available instruments that may not be completely appropriate for the specific population).

Appendix E

Limited English Proficiency Assistance

Effective August 30, 2000, the U.S. Department of Health and Human Services (DHHS) issued policy guidance to assist health and social services providers in ensuring that persons with limited English skills (LEP) can effectively access critical health and social services. All organizations or individuals that are recipients of Federal financial assistance form DHHS, including hospitals, nursing homes, home health agencies, managed care organizations, health and mental health service providers, and human services organizations, have an obligation under Title VI of the 1964 Civil Rights Act to:

1. Have policies and procedures in place for identifying the language needs of their providers and client population;

2. Provide a range of oral language assistance options, appropriate to each facility's circumstances;

3. Provide notice to persons with limited English skills of the right to free language assistance;

4. Provide staff training and program monitoring; and

5. Develop a plan for providing written materials in languages other than English, where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively.

Providers receiving DDHS funding, including SAMHSA's mental health block grants and discretionary grants, must take steps to ensure that limited English skills do not restrict access to full use of services.

Appendix F

Key Personnel

Principal Investigator

Serves as the official responsible for the fiscal and administrative oversight of the cooperative agreement and also is responsible and accountable to the funded community for the proper conduct of the cooperative agreement. The awardee, in turn, is legally responsible and accountable to PHS for the performance and financial aspects of activities supported through the cooperative agreement. The Principal Investigator also may be responsible, or designate someone, for liaison with State officials and agencies.

Project Director

Responsible for overseeing the development of a comprehensive strategic plan for creating and implementing the proposed system of care; establishing the organizational structure; hiring staff; and providing leadership in all facets of the development of the system of care. This key position should be staffed by one individual in a full-time equivalent position.

Key Family Contact

Typically, this position is filled by a parent or other family member of a child or adolescent with a serious emotional disturbance, who has received services from the public service system. This position is responsible for either setting up, or working with an existing family-run organization, that represents the cultural and linguistic background of the target population. Responsibilities include, but are not limited to, working in partnership with the awardee staff in all aspects of implementing the system of care and providing support services for families receiving services through the cooperative agreement. This key position should be staffed by one individual in a full-time equivalent position.

Youth Coordinator

This position, typically filled by a young adult, is responsible for developing activities to represent the voice of youth who have a serious emotional disturbance with staff who are charged with the programming and implementation of the system of care. Responsibilities also include developing programs for young people to facilitate their involvement in the development of the system of care.

Key Evaluation Staff

At least two full-time positions will be filled by staff that direct and coordinate the implementation of the National Evaluation sponsored by the Comprehensive Community Mental

Health Services for Children and Their Families Program. These staff will be responsible for developing the procedures for conducting a longitudinal study of children and their families served through the program. Other responsibilities include: purchasing and setting up the computer hardware and software required to enter, store, manage, analyze, and transmit data; analyzing, interpreting, and reporting results; presenting papers at key research conferences; writing and publishing results in peer-reviewed journals, as well as in publications for consumption by multiple public audiences, including policy makers, family members, and agency professionals; and incorporating youth and family members in multiple activities of the evaluation. At least two full- time equivalent positions should be designated for these key personnel.

Social Marketing-Communications Manager

Responsible for developing a comprehensive social marketing/communications strategy for the awardee community, including a social marketing strategic plan, public education activities, and overall outreach efforts. This position coordinates activities with the national communications campaign contractor. At least a half-time equivalent position should be allocated for this function.

Technical Assistance Coordinator

Serves as the central point within the system of care for strategizing and assessing the technical assistance needs of the community and as the primary link with the Technical Assistance Partnership for accessing the appropriate technical assistance. Technical assistance areas may include culturally competent practices and services, leadership, partnership/collaboration, strategic planning, wraparound planning, sustainability, family involvement, and youth involvement. At least a half-time equivalent position should be allocated for this function.

State-Local Liaison

Serves as the bridge between the State and the awardee community in efforts to create a single system of care that will be sustained through collaborative and integrated funding investments from State and/or community-based, child- and family-serving public agencies. Efforts include working to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

Appendix G

Past and Current Grant and Cooperative Agreement Communities

of the Comprehensive Community Mental Health Services Program for Children and Their Families

Grantees Funded in 1993-1994			
Project Name	**State**	**Number of Counties Included**	**Names of Counties**
East Baltimore Mental Health Partnership	MD	1	Baltimore City (Baltimore County)
Stark County Community Mental Health Board	OH	1	Stark
The Village Project	SC	2	Charleston, Dorchester
Department of Mental Health and Mental Retardation	VT	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Five Counties	CA	5	Riverside, San Mateo, Santa Cruz, Solano, Ventura
Family and Children Community Services	KS	1	Sedgewick
Wings Project	ME	4	Piscatquis, Hancock, Penobscot, Washington
Olympia	NM	1	Doña Ana
Pitt-Edgecombe-Nash Public Academic Liaison (PEN-PAL)	NC	3	Pitt, Edgecombe, Nash
Project Reach	RI	3	Providence, Kent, Washington
Wraparound Milwaukee	WI	1	Milwaukee
Multi-agency Integrated System of Care	CA	1	Santa Barbara
Youth and Family System of Care	CA	2	Sonoma, Napa
Hawaii Ohana Project	HI	1	Honolulu
Community Wraparound			

Initiative	IL	1	Cook
Project KanFoucs	KS	13	Labette, Cherokee, Crawford, Wilson, Elk, Chautauqua, Montgomery, Anderson, Woodson, Allen, Bourbon, Neosha, Linn
* Navajo Nation K'e Project	NM	5	San Juan, McKinley, Coconino, Apache, Navajo
FRIENDS Initiative - Mott Haven (South Bronx)	NY	1	Bronx Borough (County) – but encompassing only a few Census tracts around the Mott Haven community of the South Bronx
SED Partnership Grant	ND	17	Minot - Bottineau, Burke, McHenry, Mountrail, Pierce, Renville, and Ward Bismarck - Aurleigh, Oliver, Morton, Kidder, Grant, McLean, Mercer, Sheridan, Sioux, Emmons
The New Opportunities Program	OR	1	Lane
Philadelphia Kinship Care Program	PA	1	Philadelphia
Alexandria Children's Comprehensive and Enhanced Service System (ACCESS)	VA	1	Fairfax
Totals		**79**	

Grantees Funded in 1997

Project Name	State	Number of Counties Included	Names of Counties
The Jefferson County Community Partnership	AL	1	Jefferson
Intensive Services Evaluation Project	SD	1	San Diego
* Kmihqitahasultipon Project (Passamaquoddy Tribe Indian Township)	ME	1	Washington
Southwest Community Partnership	MI	1	Wayne

Central Nebraska Initiative for Families and Youth - Central Nebraska	NE	22	Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Merrick, Buffalo, Hall, Hamilton, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Franklin, Webster, Nuckolls
North Carolina Families and Communities Equal Success (FACES)	NC	11	Ayson, Buncombe, Cleveland, Guilford, Hoke, Madison, Mitchell, Montgomery, Moore, Richmond, Yancey
* The Sacred Child Project (Fort Berthold, Standing Rock, Spirit Lake, and Turtle Mountain Indian Reservations)	ND	18	Benson, Divide, Dunn, Eddy, McLean, McKenzie, Mercer, Montrail, Nelson, Ramsey, Rolette, Sioux, Ward, Williams, North Dakota; Sheridan, Richland, Roosevelt, Montana; Corson, South Dakota
Children's Upstream Services	VT	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Northwoods Alliance for Children and Families	WI	6	Forest, Langdale, Lincoln, Marathon, Oneida, Vilas
Totals		**74**	

Grantees Funded in 1998

Project Name	State	Number of Counties Included	Names of Counties
Tampa-Hillsborough Integrated Network for Kids (THINK)	FL	1	Hillsborough
Kentucky Bridges Project (3 rural Appalachian regions)	KY	22	Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe, Floyd, Johnson, Magoffin, Martin, Morgan, Pike, Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
* Mno Bmaadzid Endaad ("Be in good health at his house" - Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Ojibwa Indian Community)	MI	7	Alger, Chippewa, Delta, Luce, Marquette, Mackinac, Schoolcraft
Partnership with Families	MO	1	St. Charles
Families First and Foremowst Community	NE	1	Lancaster

Collaborative			
Neighborhood Care Center Project	NV	1	Clark
Clackamas Partnership	OR	1	Clackamas
Community Connections for Families	PA	1	Allegheny
Project Hope	RI	3	Providence, Kent, Washington
Travis County Children's Mental Health Partnership	TX	1	Travis
Utah Frontiers Project	UT	6	Beaver, Carbon, Emery, Garfield, Grande, Kane *(Also proposed: San Juan, Piute, Wayne, Rich, Daggett)*
Clark County Children's Mental Health Initiative	WA	1	Clark
Children and Families in Common	WA	1	King
* With Eagles Wings (Wind River Indian Reservation)	WY	2	Freemont, Hot Springs
Totals		**49**	

Grantees Funded in 1999-2000

Project Name	State	Number of Counties Included	Names of Counties
* Yuut Calilriit Ikaiyuqualluteng (eople Working Together") Project of the Yukon-Kuskokwim Delta Region of Southwest Alaska (58 Tribes)	AK	1	No County designations
Project MATCH	AZ	1	Pima
Spirit of Caring Project	CA	1	Contra Costa
* AKO-NES Wraparound			

System of Care	CA	2	Del Norte, Humbolt
Colorado Cornerstone System of Care Initiative	CO	4	Denver, Jefferson, Clear Creek, Gilpin
Families and Communities Work Better Together: FACT Project	DE	3	New Castle, Kent, Sussex
Family Helping Organize Partnerships for Empowerment (HOPE) Project	FL	1	West Palm Beach
Circle Around Families	IN	1	Lake
Dawn Project	IN	1	Marion
The Community Kids Project	MD	1	Montgomery
Worcester Communities of Care for Youth with Serious Emotional Disturbances	MA	1	Worcester
Putting All Communities Together (PACT) 4 Families Wraparound Initiative	MN	4	Kandiyohi, Meeker, Renville, Yellow Medicine
COMPASS	MS	1	Hinds
Care New Hampshire: Community Alliance Reform Effort	NH	3	Coos, Grafton, Hillsbourough
Burlington Partnership Project	NJ	1	Burlington
Westchester Community Network	NY	1	Westchester
North Carolina System of Care Project	NC	11	Halifax, Orange, Person, Chatham, Swain, Haywood, Macon, Jackson, Cherokee, Clay, Graham
* Nagi Kicopi – Calling the Spirit Back Project (Oglala	SD	2	Jackson, Shannon

Sioux Tribe, Pine Ridge Indian Reservation)			
Young Adult Grant Project	SC	1	Greenwood
Nashville Connection Project	TN	1	Davidson
Region II Child Mental Health Initiative: Mountain State Family Alliance	WV	12	Boone, Cabell, Clay, Jackson, Kanawha, Lincoln, Logan, Mason, Putnam, Roane, Mingo, Wayne
The Peach State Wraparound Initiative	GA	2	Gwinnett, Rockdale *(Newton County not listed in application, but part of agency's service area)*
Totals		**56**	

Grantees Funded in 2002

Ch'eghutsen': System of Care	AK	1	Athabascan conviction
Sacramento Model	CA	1	Sacramento
Glenn County	CA	1	Glenn
San Francisco System of Care	CA	1	San Francisco
Project BLOOM for Children's Mental Health	CO	3	Arapahoe, El Paso, Fremont
Partnership for Kids Project (PARK Project)	CT	1	Statewide
D.C. Children Inspired Now Gain Strength	DC	1	District of Columbia
One Community - Working Together For Our Children	FL	1	Broward
I'Famagu'onta (Our Children)	Guam	1	Territory of Guam
Building on Each Other's Strengths	ID	1	Statewide
System of Care-Chicago	IL	1	Cook
Show-Me Kids	MO	5	Greene, Christian, Teaney, Stone, Barry, Lawrence
Keeping Families Together in			

New York City	NY	1	New York City Metro Area
Puerto Rico Mental Health Initiative for Children	PR	1	Territory of Puerto Rico
Oklahoma State Department of Human Services	OK	5	Kay, Tulsa, Oklahoma, Canadian, Beckham
* Choctaw Nation of Oklahoma	OK	10	Bryant, Choctaw, McCurtain, Haskell, Pushmataha, Latimer, Leflore, Pittsburg, Coal, Atoka
Border Children's Mental Health Collaborative	TX	1	El Paso
Children's Voices, Family Choices, Community Solutions: Building Blocks for Healthy Families	TX	1	Tarrant
Totals		**37**	

* These grants were awarded to American Indian or Alaskan Native Tribes or tribal organizations. They were intended to serve only children in their tribal communities.

Appendix H

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* Can be obtained through linkages available on the www.samsha.gov web site.

Appendix I

Program Performance Measures for the Government Performance and Results Act (GPRA)

In compliance with GPRA, SAMHSA reports annually to the Office of Management and Budget (OMB) on the performance of the Comprehensive Community Mental Health Services Program for Children and Their Families. The Comprehensive Community Mental Health Services Program for Children and Their Families, in turn, obtains information for the GPRA performance report through the activities of its National Evaluation. Recipients of cooperative agreements collaborate on the development of the annual GPRA performance report by participating in implementation of the cross-site National Evaluation. The GPRA performance report includes a set of measures that are reviewed and approved by OMB on an annual basis. The currently reviewed and approved performance goals and performance measures for the Comprehensive Community Mental Health Services Program for Children and Their Families include:

Performance Goals and Performance Measures of the Comprehensive Community Mental Health Services Program for Children and their Families	
Goals	**Measures**
1. Increase number of children served.	
1.1 Increase the average number of children served in grant communities.	1.1 Average number of children receiving service in grant communities.
2. Increase interagency collaboration.	
2.1 Increase the percentage of referrals from non-mental health agencies for mental health services.	2.1 Percentage of referrals from non-mental health agencies for mental health services.
2.2 Increase the percentage of referrals from juvenile justice programs.	2.2 Percentage of referrals from juvenile justice programs.
2.3 Increase the percentage of case records that reflect cross-agency treatment planning will increase.	2.3 Percentage of case records that reflect cross-agency treatment planning will increase.
3. Decrease utilization of inpatient/residential treatment.	
3.1 Decrease average days in inpatient/residential facilities after 12 months in services.	3.1 Decrease average days in inpatient/residential facilities after 12 months in services.
4. Improve children's outcomes.	
4.1 Increase the percentage of children attending school 75 percent or more of the time after 12 months in services.	4.1 Percentage of children attending school 75 percent or more of the time after 12 months in services.

4.2 Increase the percentage of children with law enforcement contacts at entry who have no law enforcement contacts after 12 months in services.	4.2 Percentage of children with law enforcement contacts at entry who have no law enforcement contacts after 12 months in services.
5. Increase family satisfaction with services.	
5.1 Increase percentage of families satisfied with services after 12 months.	5.1 Percentage of families satisfied with services after 12 months.
6. Increase stability of living arrangements.	
6.1 Decrease percentage of children having more than one living arrangement after 12 months in services**.**	6.1 Percentage of children having more than one living arrangement after 12 months in services.
7. Demonstrate effectiveness of child and family services.	
7.1 Maintain improvement in clinical outcome after 6 months in services.	7.1 Improvement in clinical outcome after 6 months in services.

Appendix J

Values and Principles for the System of Care*

Core Values

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services, as well as management and decision-making responsibility, resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the population they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services, in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

* From Stroul, B. A., & Friedman, R. M. (1994). *A system of care for children and youth with severe emotional disturbances (Rev. ed.).* Washington, D.C.: Georgetown University Child Development Center, Child and Adolescent Service System Program Technical Assistance Center.